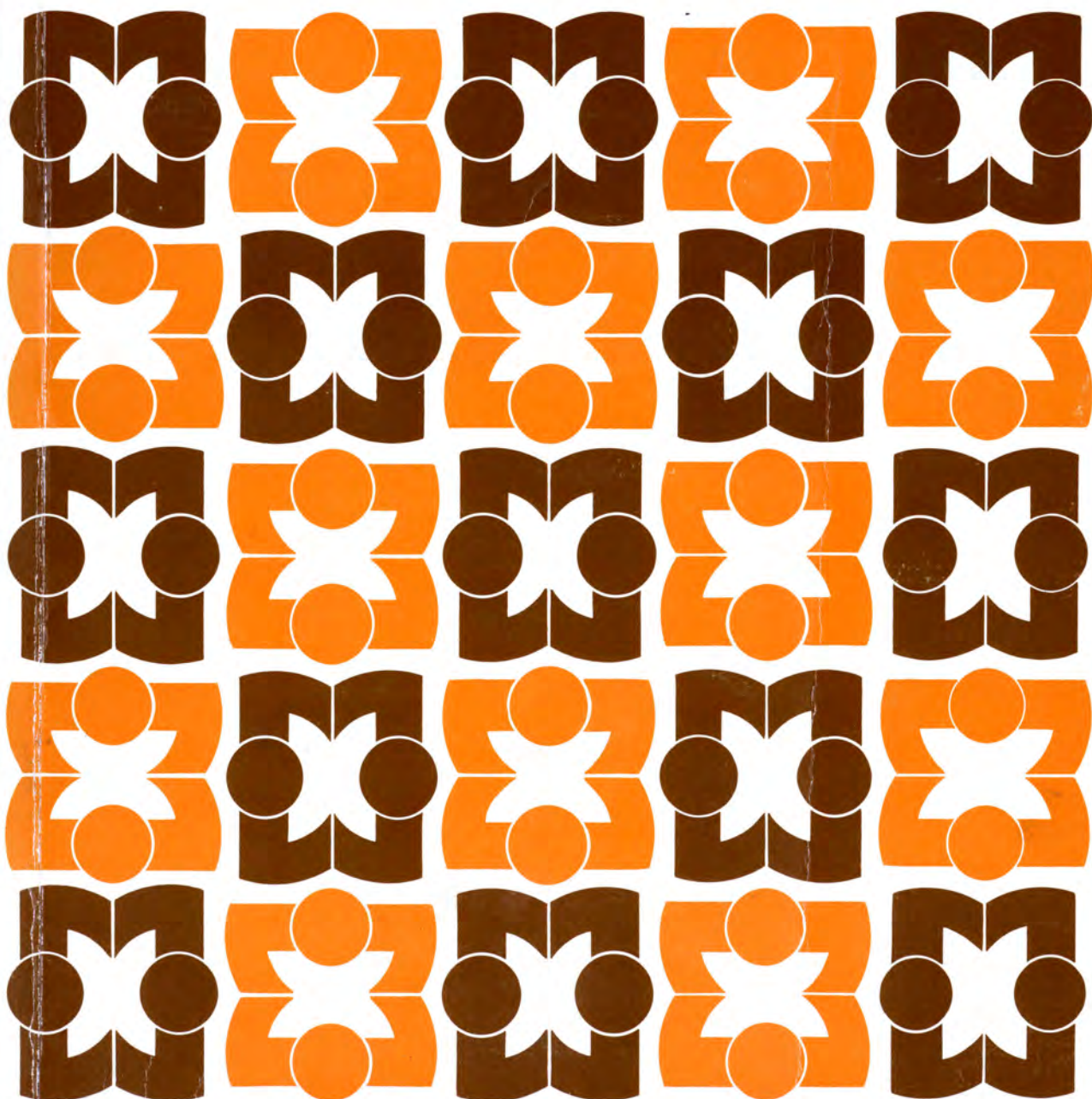


ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report Volume 3





ROYAL COMMISSION
ON HUMAN RELATIONSHIPS
Final Report
Volume 3



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ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report Volume 3

Part IV Sexuality and fertility

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ROYAL COMMISSION
ON HUMAN RELATIONSHIPS

100 William Street
Sydney
21 November 1977

Your Excellency,

In accordance with Letters Patent, dated 21 August 1974, we have the honour to present to you the Final Report of the Royal Commission on Human Relationships, prepared as at April 1977.

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Felix Arnott
Anne Deveson

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1. Sexuality

Introduction

1. The inevitable link between human sexuality and fertility has contributed to many social customs and values related to sexual behaviour, marriage, the family, the procreation and status of children. In modern times low infant mortality and effective fertility control have had an impact on attitudes to sexuality and on sexual behaviour. Traditional attitudes and strictures on behaviour have lost some of their influence. Sexual behaviour can be perceived independently of its consequences; the capacity to avoid pregnancy affects social controls on sexual behaviour. Although there has been a relaxation of earlier and more rigid codes of behaviour, many people are still not able to take a responsible approach. Ignorance is a contributory factor.
2. The sexuality or sexual nature of a person includes the following aspects:
 - (a) the male or female characteristics and functions of the reproductive organs and other physiological differences related to these
 - (b) the possession of sexual powers or capability of sexual feelings; the ability to respond sexually
 - (c) sexual behaviour including intercourse between the sexes
 - (d) perception of one's own sexual nature; behaviour related to this perception.

Sexuality and sexual problems

3. We have not conducted a full-scale inquiry into sexual behaviour and attitudes in Australia. Our project to survey young people had to be abandoned. We have referred to studies of sexual behaviour which have been published in Australia and overseas.¹ Statistics throw some light on behaviour, e.g. the fact that up to 40 per cent of live first births are conceived or born outside marriage², and the abortion rate among single women, gives some indication of sexual relations outside marriage, especially among young people; in some cases these are stable relationships and in other cases they lead to marriage. The number of reported VD cases gives some cause for concern.
4. A survey of contraceptive practice among young male university students was carried out for the Commission.³ The survey showed that sexual activity began for 10 per cent of the group prior to 16 and for 66 per cent before 20. The researchers found a preference for intercourse within a steady relationship.
5. The Scott survey of 203 Melbourne people found that they had been given little sexual instruction by their parents and knew little of their parents' sexual relationships⁴; 65 per cent felt they would be prepared to discuss their relationships with their own children⁵; 62 per cent had had some formal sex education. Seventy-eight
 1. A. C. Kinsey et al., *Sexual behaviour in the human male* (Saunders, London, 1948); A. C. Kinsey et al., *Sexual behaviour in the human female* (Saunders, London, 1953); Schofield et al., *The sexual behaviour of young people* (Penguin, Harmondsworth, 1965); Robert Bell, *A sex survey of Australian women* (Sun Books, Melbourne, 1974).
 2. Ruzicka, 'Age at marriage and timing of the first birth', *Population Studies* 30, 3 (in press).
 3. F. C. L. Beighton & J. B. Cole, Attitudes of young males to contraception, Commission research report, no. 5, 1976.
 4. Alan J. Scott, Attitudes to sexuality, Melbourne, Commission research report, no. 7, 1976, p. 12; see also Sue Wills, Eva Cox, Gaby Antolovich, Attitudes to sexuality, Sydney, Commission research report, no. 8, 1976.
 5. Scott, Commission research report no. 7, p. 14.

per cent had been allowed out unchaperoned since 16 and 55 per cent thought it would be helpful for boys and girls to gain practical sexual experiences as part of growing up. While 69 per cent thought that sex could be enjoyed as a simple physical relationship, 95 per cent thought sex relationships were more satisfying when combined with emotional relationships.⁶

6. A study of 171 women and girls attending the State Health Department's Womens Clinic in Brisbane, for treatment for VD, reported that:

64.91 per cent of patients interviewed believed that pre-marital sexual relations were now an accepted form of social behaviour, 36.25 per cent of the 64.91 per cent being of the opinion that sexual relations with a casual partner were also socially acceptable, and this group was obviously very promiscuous. Some 14.62 per cent had some guilt feelings about pre-marital or extra-marital sexual relations, while 8.18 per cent disapproved. The last-mentioned group mainly consisted of married women who had been infected by their husbands In the present group 52.63 per cent exhibited a lack of concern about their venereal infection

Many young girls stated that they did not enjoy sexual relations, their behaviour being motivated by social urges rather than biological ones, and their need for a man appeared social rather than sexual.⁷

7. In 1973 Professor Robert Bell published *A sex survey of Australian women* based on data relating to 1442 women. The pattern presented was one in which private sexual morality had changed considerably without any consequent change in public morality, i.e. in which actual behaviour is not matched by a change in public attitudes.⁸

8. The general picture presented in these and in other surveys is that of a breakdown of traditional controls on sexual behaviour.

9. Although there is widespread agreement about the need for people to understand their sexuality and 'to enjoy the happiness of their physical sexual loving by free and responsible decisions', there are many barriers to the achievement of this. They arise in part from ignorance and misinformation, in part from false expectations and from views of male and female roles, and in part from community attitudes which restrict open discussion and the imparting of information. Lack of access to services is another important factor, and in some cases the relevant professionals, including doctors, are moralistic and judgmental.

10. Dr Bob Montgomery, senior lecturer in clinical psychology at La Trobe, wrote:

My impression, based on the research evidence and on our clinical experience, is that the level of satisfaction in sexual relationships in the Australian community is extremely low, and this contributes to marital disharmony, marital breakups and personal unhappiness. It is my belief that the two major causes of this phenomenon are the general lack of an honest and meaningful sexual education coupled with the popularity of misleading attitudes and myths relating to sex, particularly the double standard.¹⁰

Bell's survey suggested that a low level of satisfaction in marriage may contribute to extra-marital sexual activity.

11. Psychosexual problems such as frigidity and impotence are caused by and also lead to anxiety and repression, and to misunderstanding. Dr Frank Weston, an Adelaide psychiatrist who specialises in dealing with sex difficulties, described some of these misunderstandings as follows:

6. *ibid.*, p. 23.

7. B. A. Smithhurst & J. L. Armstrong, *Medical Journal of Australia* 1 (1975), pp. 339-43; Exhibit 103.

8. Bell, p. 165.

9. Submission 1146, Dr J. Billings.

10. Submission 1054, Dr R. B. Montgomery; see also Submission 105, Dr G. Dudgeon.

One of the misunderstandings is that men know how to arouse women. Some men learn by chance, some may learn by instruction. Many do not know unless the woman tells them; they won't find out. Women cannot tell them because they are supposed to know. They cannot ask what they are supposed to know and if the woman does not know, on top of that, anyway, it is a bit of a bind.¹¹

12. Dr Jules Black, a practising gynaecologist who specialises in sexual therapy, stated that, of a review of female and male patients, only three women in 750 were completely sexually aware.¹² Many of his women patients were unaware of their own sexual anatomy or of the factors involved in sexual arousal.

13. Factors contributing to psychosexual problems are lack of information and faulty information. The low level of knowledge about sex and sexuality was mentioned in Part II and we there quoted the comment that 'ignorance is not bliss'.¹³ The ignorance also includes a great deal of misinformation. Contraceptive practice was also said to lead to frigidity.¹⁴ Sometimes formal instruction itself contributes to the problem by its deficiencies, by concentrating on the technical rather than the emotional sides, and by reinforcing or conveying attitudes on what is or is not appropriate.

14. Some submissions suggested that society instils guilt in individuals¹⁵, and some blamed churches for this.¹⁶ What is suggested is that the social controls tend to emphasise the forbidden aspects of sex (the don'ts) rather than impart information about the positive aspects of sexual expression.

15. Dr Montgomery considered that ignorance of the need to take responsibility for one's sexual response arises partly from moral attitudes. He informed the Commission that he believes in teaching masturbation techniques to women as part of their treatment in learning to take responsibility for sexual pleasure, and to overcome sexual anxiety.¹⁷ Dr Weston¹⁸ and Dr Ron Farmer¹⁹ similarly believed masturbation helpful for a person's sexual development, particularly for women, as it permits them to accept responsibility for their sexual satisfaction instead of leaving the responsibility entirely with the man.

16. Yet it is claimed that in some sex education programs masturbation as a topic is avoided. Religious attitudes may also inhibit masturbation and its discussion.²⁰ This is unfortunate because young people may be left with a feeling of anxiety, or even guilt, about their sexual appetite.

17. Many psychosexual problems can be treated and overcome; a body of knowledge has been built up about human sexual response.²¹ Films such as *Sexuality and communication* and some books can play a part in popularising this knowledge and in releasing inhibitions especially when they emphasise the universality of sexual

11. Evidence, p. 1341, Dr F. Weston.

12. Evidence, pp. 34-7, Dr J. S. Black.

13. Submission 1004, P. Battersby.

14. Submission 105, Dr G. Dudgeon.

15. Submission 1214, Mr Max Wilson.

16. Submissions 1232, Mr W. J. Helem; 193, David Morrow; 307, Mrs Sandra Vaughan; 732, G. & C. Somssich.

17. Submission 1054, Dr R. B. Montgomery.

18. Evidence, pp. 1339 ff, Dr F. Weston.

19. Submission 433, Dr Ron Farmer; see also E. R. Csillag, Treatment of female sexual problems (unpublished).

20. The Vatican, Declaration on certain questions concerning sexual ethics, January 1976, described masturbation as 'an intrinsically and seriously disordered act'.

21. e.g. Havelock Ellis, *On life and sex: essays of love and virtue* (Doubleday, NY, 1937), p. 103; W. H. Masters and V. E. Johnson, *Human sexual response* (Little Brown, Boston, Mass., 1966); W. H. Masters and V. E. Johnson, *Human sexual inadequacy* (Little Brown, Boston, Mass., 1970).

problems and their solution. Dr Weston instanced *Forum* as useful in this regard.²² The importance of developing adequate skills in communication has been mentioned in Part II but needs continually to be emphasised.

18. Clinical psychologist Bettina Arndt said research had shown that one in three couples claimed to be sexually dissatisfied.²³ The mass media, in her view, were a means of contacting large numbers of people quickly. Media discussion could fairly readily overcome ignorance. Many people believed that their attitudes or practices were unusual and felt guilty about them. In some cases, the knowledge that many others shared similar behaviour reduced the tension and guilt of the person. In others, where help was necessary, media discussions could make it known where to find appropriate assistance. At one stage the Broadcasting Control Board recommended that she be not permitted to make further broadcasts on radio or television. This recommendation has now been withdrawn.

19. There were differing views from the experts about the parental role in education. One of our witnesses, Dr Farmer, emphasised the importance of parental influence and the need for parents to impart not only technical information but also the emotional aspects of sexuality.

All that is important is that the parents communicate openly and honestly at all times with the child about sex in response to the child's queries . . . The parents have a very rich storehouse of sexual information based on their own experience with sex, and the time they have spent in thinking about sex.²⁴

20. Dr Weston, however, felt that parents were not always helpful.²⁵ These views give weight to the calls for parental education and for involving parents in human relationships education. Parents need to be encouraged to participate in this aspect of their children's education but this is possible only when they feel comfortable about it.

21. A main difficulty for people with psychosexual problems seems to be the reluctance with which they approach experts for advice; many appear unable to identify the sexual problems adequately. Doctors are often unable to deal with patients. One submission said:

The distressing situations faced by people who have problems which are related to sex in any way must be seen to be believed . . . The shame, guilt and self-disgust aroused in people by doctors and other community services when they have to declare themselves to be sexual beings is inhuman.²⁶

22. The Family Planning Association of Western Australia commented on the lack of medical education in sexuality and doctors' difficulties in relating to and coping with the sexual problems of their patients.²⁷ They called for better professional training in this area, as did many others. This question is fully considered in Part III.

23. Specialisation in sexual counselling and treatment is a recent phenomenon and, of course, it requires a sufficient number of professionals who are themselves comfortable and emotionally adequate.

22. Evidence, p. 1342, Dr F. Weston.

23. Evidence, pp. 2608-22, Ms Bettina Arndt.

24. Submission 433, Dr R. Farmer.

25. Evidence, pp. 1432 ff, Dr F. Weston.

26. Submission 535, Yvonne Foster; see also Evidence, pp. 38 ff, Dr J. Black.

27. Submission 253, WA FPA.

24. We heard evidence about specialist clinics in Sydney, Melbourne and Adelaide; Family Planning Association clinics also offer sexual counselling. We were told, however, that it is difficult for them to cope with the large number of persons who seek assistance. The main problems referred to one clinic were said to be masturbation worries, impotence and menopause.²⁸

25. While most people agree that the ability to cope with one's own sexuality is desirable, not all could agree on how to achieve this end. Dr Clair Isbister expressed the following view:

There is no evidence that teaching procreational or recreational sex improves man-woman relationships, marital stability, family life or child care, or that it reduces the incidence of sexual intercourse in adolescence and the percentage of illegitimate births.²⁹

A student counsellor made the point that society is 'expecting too much of sex'; that it is required to be fulfilment therapy, the final solution. Sex, he says, cannot meet such expectations, and he instances the 'often disastrous one-night stands of the lonely and unpaired'. This counsellor advocates the establishment of human relationships courses in schools, for 'learning to love'.³⁰

Conclusions

26. The Commission concurs with the view that 'the ethics of sexual relationships are based on . . . principles of co-operation, self-expression, concern for others'.³¹

27. Maturity in sexual matters involves the acceptance of responsibility for sexual relationships. This in turn requires knowledge and education for human relationships, encompassing at least the processes and functions of sex and reproduction, and a full comprehension of the consequences of sexual life including the positive aspects of sexual expression and adverse consequences such as sexually transmitted disease.

28. Education should provide acceptance of sexuality as:

. . . an expression of the total personality [producing] . . . individuals each confident of his or her own identity and being tolerant of the differences which exist with others.³²

29. Many people obtain only partial and distorted views of physiological and other matters related to sexuality because of the intrusion of moral and emotional factors into what should be, on one level, an objective factual presentation of information. It is clear to us that the formal aspects of this educational activity need to be in the hands of professional educators because parents often do not have sufficiently accurate information and many are too embarrassed to speak about it.

30. Parents are, of course, central as primary role models of human relationships for their children. Even where parents are unable to deal with the facts of sex and relationships, they are the main examples followed by their children in learning how to relate to other people both sexually and generally.

31. . We see a need for adult education and for services to help people identify sexual problems and seek help with them. The education needs to be in the context of human relationships and should emphasise the role of personal responsibility in sexual relationships. There is a need to recognise the individual distress arising from sexual problems and to regard satisfactory sexual functioning as an important aspect of

28. Submission 535, Yvonne Foster.

29. Submission 455, Dr Clair Isbister.

30. Submission 512, Geoff Ainsworth.

31. Submission 569, William Pitty.

32. Submission 886, RACGP.

health and well-being. Health care programs should provide for sexual health in acknowledgment of its importance to mental and physical health and to social adjustment. Professionals in medical and counselling fields should receive adequate training in dealing with sexual problems, at least sufficiently to enable referral to specialists where necessary. The establishment of counselling units as part of facilities offering fertility control and other related services should be supported. More trained professionals, including clinical psychologists, therapists and social workers are needed. Fees for their services should be covered by Medibank and other health insurance funds.

Sex and the handicapped

32. Until recently sexual activity for the handicapped was often regarded as a taboo topic, or thought to be impossible. Those mentally handicapped from birth were rarely given any information or help with the basics of sex and the physically handicapped were told to think of other things. This was even the case with those physically handicapped by accidents in later life. Yet it is important to realise that sex is more than just the act of coitus; touching, nearness and companionship are also components of a satisfying relationship. Loving relationships may be of even greater importance for this group, since the range of activities open to them may be more limited than to the able-bodied.

33. Attitudes are changing, but slowly. The facilities for counselling, education and support in this area are still patchy and, in some parts of Australia, non-existent. We had considered a research project on sexuality and the handicapped but had not time or resources to complete it. Further research is most desirable.

Rehabilitation and information

34. There is an obvious need for sexual rehabilitation and for imparting techniques adapted to the individual needs of the handicapped. These services should form part of the total health care program in this country. They could be provided by hospital departments, or through human sexuality programs, Family Planning Associations, special schools and groups for the disabled. These rehabilitation programs could include lectures, group discussions and private consultations. The partner should be present wherever possible and topics should cover:

- effects of injury or illness on sexual functioning
- adjustment to new ways of functioning
- adjustment to role changes and new self-image
- techniques for new sexual functioning
- sexual options

35. The Family Planning Association, NSW, informs us that it is prepared to run or aid in the setting up of such programs if the institutions concerned would accept the need for them.

36. The provision of such information is equally important for the 'helping' professions (nurses, doctors, orderlies, social workers, clergy, physiotherapists, occupational therapists), for medical students, and for friends and relatives of the handicapped. Professional personnel should learn to understand the sexual needs and options available to the disabled in their basic training. Those workers who experience difficulty working with the handicapped should be helped to understand their own views and limitations.

37. Rehabilitation centres and hospitals for the physically disabled should organise continuing educational programs on sexuality for their staff (both medical and paramedical). The Austin Hospital, Melbourne, has begun a program of this type. Regrettably other hospitals have not followed suit.

38. Follow-up counselling services are needed for disabled persons who are no longer patients in rehabilitation centres.

Removal of constraints

39. It is easy for those in charge of institutions to over-protect the handicapped, even when their charges are adults. Thus, in Victoria recently, two professional workers were dismissed for assisting and encouraging a handicapped couple in their relationship. It appears that there is a great need for administrators to acknowledge the sexual needs of handicapped people in the planning of facilities in institutions and hostels. Some still prohibit men and women from visiting each other's rooms.

40. There are some people who seem to wish to impose their own moral ideas on handicapped people; rather the latter should be given sufficient information and help to work out their own sexual options.

41. Hence all institutions need to make sure that handicapped people can enjoy some privacy. Everyone needs to be alone at some time and the handicapped person is no exception.

Education

42. We welcome the current moves in some States to integrate handicapped with other children. Desegregation of handicapped young people would allow them more social contacts. For example, blind children who are educated in sex-segregated schools can grow up with no direct knowledge at all of contemporaries of the other sex.

43. Institutions that house or educate handicapped people of any age should have continuing educational programs on sexuality in which both residents and staff should participate. Staff need to be able to answer questions knowledgeably and to offer informed support. Educational programs should cover:

- basic anatomy and physiology
- reproduction
- sexual behaviour
- sexual attitudes
- sexual responsibilities

We were told that blind children have a special need for teaching aids, such as models, to help them to understand physiology and anatomy.

44. In Adelaide the South Australian Family Planning Association helps to organise courses on sex for the handicapped. The Melbourne University Social Biology Resources Centre runs courses on sexuality, including sex for the handicapped. The NSW Family Planning Association has been running such courses in some private and governmental institutions but there needs to be a more intensive and more far-reaching educational plan.

45. 'Special education' teachers should participate in intensive courses on sexuality during their training to enable them to carry out similar programs in the schools.

Social activities

46. One of the greatest problems facing the handicapped population is isolation. Handicapped people need to meet and mix and form relationships with other people. Hence the value of community groups. Single sex institutions, isolated from the rest of the community, do nothing to help the handicapped person overcome loneliness. Future planning should include small-scale 'mixed' hostels in the community, with back-up support systems available when needed.

Conclusion

47. It does seem that, in general, there has been a failure to acknowledge and accept the needs of the handicapped in social planning and administration of institutions. The general public should be made aware of the problems facing them in matters relating to sexuality. Our view is that understanding of, and sensitivity to, these needs should be fostered. The ability to develop a satisfying sexual relationship may be an important factor in the well-being of a handicapped person and in his or her ability to cope adequately with life. To quote Alex Comfort, 'Virtually nobody is too disabled to derive some satisfaction and personal reinforcement from sex'.³³

Sex and the ageing

48. Much of this report concentrates on the sexuality of young people and their need for education, information and services. It should not be overlooked that sexual needs do not disappear with advancing age; they may change and they may give rise to problems which need consideration.

49. In a paper given at a family planning symposium, in July 1976, Dr Gillian Diamond wrote:

The messages we have received tell us that old age brings a period either of asexuality or abnormality. All the education you have received during your life will have taught you that old men are 'dirty' and older women 'don't'. The message is sex is wrong if you are old and this also applies if you are mentally ill, mentally retarded or physically handicapped. All our institutions are organised so that this message is reinforced.³⁴

Others have pointed out the barriers which are put up to inhibit and discourage older people from engaging in sexual activity.³⁵ The medical and nursing professions and others concerned with the care of the ageing should be aware that they have sexual needs, and that there may be problems due to the ageing process or to the loss of a partner.³⁶

50. The organisation and administration of institutions which care for old people on a long-term basis too often ignore their sexual needs, even to the point of separating husbands and wives. Double beds may be excluded from nursing homes and hostels, there may be no privacy and overnight visits from members of the opposite sex may be forbidden. We regret this lack of understanding (which is not universal) and urge that attention be given to the needs of old people in the planning and administration of institutions.

33. Alex Comfort, in T. O. Mooney, T. M. Cole and R. A. Chilgren (eds), *Sexual options for paraplegics and quadriplegics* (Little Brown & Co, Boston, 1975), foreword.

34. G. Diamond, Education and sexuality (paper delivered at the 'Family Planning and the Law' symposium, Monash University, 3-4 July 1976), p. 4.

35. Mrs B. Barnard, psychologist (address to a seminar on 'Ageing and the five senses', South Australian Council on the Ageing Inc., 24 November 1976).

36. See Theodore M. Cole, 'The physician's role in working with the sexuality of the elderly', in J. T. Kelly (ed.) *Perspectives on human ageing* (Minneapolis, 1976); Ivor Felstein, *Sex in later life* (Penguin, 1973); Alex Comfort, *A good age* (Blayley, London, 1976), p. 192.

51. It is sometimes more convenient for elderly people to cohabit rather than to marry. Our attitudes should take into account that marriage reduces the amount of the pension received by a couple. We need to develop more realistic attitudes and understanding of the ageing person as a sexual person, and recognise that most aged persons are mature, responsible and capable of making decisions.

Sexuality and life cycles

52. Our terms of reference direct attention to the 'physical, psychological and sexual problems experienced by women in adapting to marriage and before, during and after menstruation' with reference to medical training. Although this term expressly directs our attention to the sexual problems of girls and women, we are, of course, aware that the physical changes of puberty are just as important for boys as for girls.³⁷ The psychological adjustment of a male to the stages of his sexuality can give rise to problems for him which are potentially serious and which may need the help of the professional services to which we have referred. Boys and girls both need help in understanding the physiology of their own sex and of each other's sex. Their anxieties should not be allowed to build up, but should be given opportunities for discussion and explanation. For women, the stages of the sexual life cycle have special impact and can cause problems not necessarily connected with any sexual relationship.

Menstruation

53. A girl's physical introduction to the connection between sexuality and health usually occurs at the menarche or beginning of the menstrual function. The function diminishes when a woman is in her 40s or 50s, and when it ceases she has passed child-bearing potential; this period of termination of fecundity is called the menopause. Doctors understand menstruation and menopause as endocrine events, but they often ignore the effects these events have on the woman's life.

54. The onset of female puberty has advanced over the last 100 years or so and the menarche now occurs on average at 13.³⁸ A recent small survey found that 9 per cent began menstruation at 10.³⁹ This is highly significant for consideration of sexual behaviour and of sex education in schools. Many girls begin menstruation in ignorance or in fear because of the inadequacy of their parents (or of the education system) to prepare them for the event:

It was a shock to me because my mother didn't tell me anything and I wasn't prepared and I was embarrassed to tell my mother because she didn't explain anything to me.⁴⁰

School programs should try to fill the need which some girls must have of a proper explanation of menstruation.

55. Menstruation is often a traumatic experience for girls and can be a painful and fatiguing time for many women.⁴¹ Study of the phenomenon has been confined mainly to academic interest in endocrine, gynaecological and psychiatric research. One contribution to practical understanding of the impact of menstruation on the

37. See 'The teens', a series of ABC radio broadcasts about the 12-15 age group (1974), pp. 15-16.

38. Carl Wood, 'Gynaecological survey in a metropolitan area of Melbourne', *ANZJOG* 12 (1972), p. 147; Dr Lucienne Lanson, in *From woman to woman* (Penguin, Harmondsworth, 1975), states that in the US the average age for the start of menses is 12½ and that by 2000 it will be close to 11 years 9 months.

39. Evidence, p. 550, Prof. Carl Wood.

40. Teenager in 'The teens' (ABC, 1974), p. 25.

41. D. F. Roberts, M. J. Danskin, S. Chinn, 'Menarcheal age in Northumberland', *Acta Paediatrica Scandinavica* 64, 6 (1975), pp. 845-52.

individual is Dr Katherine Dalton's work, compiled in *The menstrual cycle*. The social implications are suggested in their proper perspective. In Britain in 1960 the cost to industry of lost productivity associated with menstruation in workers or workers' partners was an estimated 120 million working days. In the USA the cost in one year was \$5 thousand million.⁴² Women in the pre-menstrual period are more likely to be involved in accidents, to attempt suicide and commit crime than they are at other times in the cycle. Eighty-four per cent of crimes of violence in French women were said to have been committed just before or during menstruation.⁴³ Menstrual periods are also associated with emotional conflict and with display of emotions of attraction and hate. They are 'characterised by relatively poor impulse control'.⁴⁴

56. Menstrual-associated symptoms can be headache, pelvic pain and depression; they are often accompanied by impaired performance and a decline in motor co-ordination. Pain in connection with menstruation is often accepted as normal. Professor Carl Wood made the following comment:

. . . women will accept a burden in our society. I think they are slowly throwing this off to some extent but if you allow a woman to actually talk to you about her menstrual cycle and menstruation, it is quite surprising what she accepts . . . as her lot.⁴⁵

Professor Wood's observation is partly based on a study of 990 women in Prahran, Victoria, carried out in 1968-69, which found that half suffered menstrual disturbances which affect their life, accompanied by periods which were either painful, prolonged or heavy.⁴⁶ Symptoms were more frequent in the presence of psychiatric illness and psychoneurotic symptoms; smoking and medication were more common in patients with menstrual symptoms. Professor Wood commented:

Many men . . . have no knowledge of female menstruation and therefore are unable to understand why the person they are living with has changes of mood, not necessarily bad changes but the moods do change, and men need to be educated into what is menstruation; how a woman feels if she is bleeding heavily or abnormally or having pain and how this will affect her life in relation to him, how she feels about cooking the meal, having intercourse or anything else he needs. This sort of education does not exist in most male schools.⁴⁷

He stressed the need for further research into the effects of menstruation on women's role and into the psychological and social facts affecting menstruation.

57. We agree, and would emphasise that traditional attitudes which regard menstruation as dirty or demeaning may have a substantial psychological effect on the attitudes and behaviour of women.

58. Some action can be taken to relieve the effects of menstruation; it is possible to delay the onset of menstruation by taking progestagen where some important event is planned to occur.⁴⁸ Nevertheless more needs to be understood. The introduction to a recent publication, *The curse of Eve*, commented:

42. K. Dalton, *The menstrual cycle* (Penguin, Harmondsworth, 1969), p. 129.

43. W. R. Cooke, *American Journal of Obstetrics and Gynaecology* 49 (1945), p. 457.

44. D. G. Hertz, M. R. Jensen, 'Menstrual dreams and psychodynamics', *British Journal Medical Psychology* 48, 2 (1975), pp. 175-83; see also P. Bergsjö, H. Jenssen, O. D. Vellar, 'Dysmenorrhoea in industrial workers', *Acta Obstetrica Gynaecologica Scandinavica* 54, 3 (1975).

45. Evidence, p. 548, Prof. Carl Wood; see also Evidence, p. 1439, Dr Johnson.

46. Evidence, p. 550, Prof. Carl Wood.

47. *ibid.*, p. 548.

48. Dr M. Smith, 'Is menstruation really necessary?' in K. Dalton (ed) *The curse of Eve* (National Symposium on Menstruation and Menopause, Royal Society of Medicine, 1975).

. . . the medical profession has an opportunity to help women's move for equality. The physiological handicaps are not insurmountable, but they do require a better understanding and more sympathetic consideration.⁴⁹

59. We conclude that too little is known about the menstrual cycle. There is a need to conduct further research into the psychological needs of the adolescent girl, into the health and social problems of menstruation, the menstrual cycle and dysmenorrhea. Information about these matters should be incorporated into courses on sexuality for boys and girls.

Menopause

60. The menopause, or climacteric, is the physiological cessation of menstruation. It occurs usually between the forty-fifth and fiftieth years of life. It is characterised by altered hormonal levels.⁵⁰ There appears to be no automatic loss of or decrease in sex drive; and for some women sexual enjoyment may improve as the fear of pregnancy disappears.⁵¹

61. Undoubtedly, however, the menopause, or 'change of life', is a period of difficulty for many women.

At no other time in a woman's life is there such a complex interplay between physical and psychological factors as during the menopausal years. Along with the physical stresses brought about by hormonal imbalance, the psychological and emotional reaction of each woman to this normal transition will vary depending upon her previous life style, attitudes and self-image.⁵²

We understand that in some cultures the menopause is positively welcomed; this could well be investigated further.

62. Summers suggests that the menopause may be as much a social as a physical event for a woman.

Large numbers of women experience depression on reaching menopause. It is difficult to know the extent to which this is a learnt response to the idea that already 'worthless' women have even less value once they are no longer able to fulfil the main role of women in a patriarchal society, and how much is hormonally induced . . . Children are usually grown up and have often left home when their mothers begin menopause. It is often also the time at which the husband's job is most demanding and requires him to be away from home for long periods each day . . . All too frequently the menopausal woman cannot but see her life is over: she knows of little else to do with her life except care for her husband and children, yet now they barely need this care.⁵³

63. The social aspect of menopause—the transition from one phase of a woman's life to another with consequent identity problems—is not always acknowledged in the medical treatment of menopausal symptoms. One of our witnesses, Dr Jean Hailes, pointed out that:

There is evidence that only 15 per cent to 20 per cent of women go through the menopause free of symptoms.⁵⁴

Another submission said that women were unable to get hormonal treatment for menopause; they were often told by doctors to grow old gracefully⁵⁵ although a few enlightened ones were willing to help.

49. Dalton, *ibid*.

50. Dr J. Christie Brown, 'The menopause', *ibid*; see also Lanson, p. 285.

51. Lanson, p. 291.

52. *ibid.*, p. 285.

53. Anne Summers, *Damned whores and God's police* (Penguin, Melbourne, 1975), p. 100.

54. Evidence, p. 512, Dr J. Hailes; see also Lanson, p. 289.

55. Submission 535, Yvonne Foster.

64. Dr Hailes has carried out research on the menopause at Prince Henry's Hospital in Melbourne. Her attempt to follow a large sample in about 1970 failed to meet its desired number of patients to study. She attributes this lack of success to the view that women should 'put up with these symptoms because their mothers did'. She told the Commission that menopause need not be 'put up with', and could be treated. But she said public education was needed to advise women of this, and medical education should include it. Questioned about oestrogen therapy she said:

... women apparently feel fine with it ... However ... it is not the only solution, since there are many other symptoms which need to be specifically treated.⁵⁶

Others have also questioned this form of treatment and pointed to the need for further research on its effects.⁵⁷

65. Dr Hailes was concerned at the emotional, rather than physical, stresses of menopause. She emphasised the need for new research.

66. A study of 539 women in Britain indicated:

... a high prevalence of minor psychiatric illness in women aged 40-55 years ... before the menopause and lasting until about one year after menstrual periods had ended.

Further research was called for.⁵⁸

67. We support the calls for further research into health problems of menopause. The results of such research and information already available should be incorporated into medical education and into education on sexuality. The Family Planning Association organises some menopausal counselling clinics. Action such as this should be supported and encouraged.

Male and female cycles

68. Periodically this century endocrinologists have begun to show evidence for a monthly cycle in the male, similar to that of the menstrual cycle in the female. Hormone and mood changes in men have been studied and show pronounced hormonal fluctuation.⁵⁹ Contemporary research investigates the probability of synchrony among people who live together. In 1971 a Harvard scientist found that women living together in college dormitories, or some type of communal arrangement, tend to show similar temperature cycles, and to menstruate simultaneously.

69. In Victoria the researcher Margaret Henderson has recorded that men, as well as women, show periodic emotional and physiological changes, sometimes with symptoms similar to those which characterise the female cycle. There is evidence in her research of an hormonally related male temperature cycle, and of synchrony with a cohabiting, ovulating female.

This consideration arose out of the observation that some menstrually related conditions also occur periodically in men, e.g. migraine, depressed moods, asthma and alcoholic bouts.⁶⁰

56. Evidence, p. 516, Dr J. Hailes.

57. Christie Brown in Dalton (ed.)

58. C. Barbara Ballinger, 'Psychiatric morbidity and the menopause; screening of general population sample', *British Medical Journal* 3, 5979 (1975), pp. 344-6.

59. Estelle Ramey, 'Men's monthly cycles', *Selection of readings from Ms magazine*, p. 175: 'In Denmark ... a careful, 16-year study was conducted in which male urine was tested for the fluctuating amounts of male sex hormones it contained. The result: a pronounced 30-day rhythm was revealed through the ebb and flow of hormones.'

60. M. E. Henderson, Conditions related to the menstrual cycle in women and evidence for a male hormonal cycle, in Proceedings of the Womens Health Conference, Uni. of Queensland, 25-29 August 1975 (in process of publication by AGPS for the Australian Department of Health). A summary of this paper appeared in *Health* 25, 4 (1975) p. 7.

She found that when the:

. . . characteristic mid-cycle temperature drop, associated with ovulation in the female, occurred—there was a similar temperature fall the same morning in the cohabiting male . . . Two homosexual males living together also showed the characteristic mid-cycle synchrony.⁶¹

The complexity of how synchrony is conveyed, or achieved, has yet to be understood. In view of the possible effects on human relationships, we think that there is a case for further research in this area.

70. There might be a tendency to place too much emphasis on cycles as an explanation for various ills. It is sometimes complained that a general reaction by male doctors to female problems occurring anywhere between the ages of 35 and 50 years is to attribute them to menopause. This biological explanation ignores the possibility that menopausal problems may themselves be simply symptoms of a deeper malaise concerning the whole life and identity of a woman, and the attitude of society to older people.

71. The tensions of 'normal' married life can be severe for a woman even before she reaches menopause. Depression in women may be a response to these tensions. Depression is also taken to be an inevitable part of aspects of the female role; post-partum depression and pre-menstrual tension would be the other main examples along with menopausal depression. Depression often leads to drug taking in many cases, and this in turn is connected with a high incidence of suicide attempts:

. . . mainly by over-consumption of the very psychotropic drugs which were intended to provide relief from depression, anxiety or insomnia.⁶²

Conclusion

72. We conclude that there is a need for further research into the psychological needs of the adolescent girl, and into the health and social problems related to the menstrual cycle. Life cycles and synchrony of cycles should also be researched. The NH & MRC, the School of Social Biology and the proposed Institute of Human Reproduction and Sexuality should encourage research in this area and should not limit such research to one sex. Medical education should include information about these matters, as should all education programs on human sexuality.

Sexually transmitted diseases

73. Ignorance of sexuality contributes to risk taking, to early sexual experience and to unprotected intercourse with the attendant risks of pregnancy and venereal disease.

Syphilis and gonorrhoea

74. Syphilis is transmitted by sexual contact or by infection of the child *in utero*. It has three stages, the first characterised by a chancre or painless sore on the part affected, the second by lesions of the skin and mucous membranes, the last by degeneration of bone, muscle and brain tissue. The only known cure is penicillin in large doses.

61. M. E. Henderson, Evidence for a male menstrual temperature cycle and synchrony with the female menstrual cycle (a paper given to the Combined Meeting of the Endocrine Societies of Aust. and NZ, 15–18 February 1976), *ANZJMed.* 6, 3 (1976), p. 254 (abstract only); a summary of this paper appeared in the *AMA Gazette*, 1 April 1976, p. 9.

62. B. Furnass, 'Changing patterns of health and disease', in M. Diesendorf (ed), *The magic bullet* (SSRS, ACT, 1976), p. 15.

75. Gonorrhoea is more prevalent than syphilis. It is characterised usually by a burning sensation at urinating and a discharge of mucus from the membrane of the vagina or urethra.

76. Both these venereal diseases display characteristic symptoms, yet can go unobserved, especially in women. The 1960s and 1970s have marked a resurgence in world venereal disease. In Australia incidence is according to table IV.1.

Table IV.1 Incidence of notified venereal disease in Australia for calendar years 1975 and 1976

| State | 1975 | | | 1976 | | |
|-------|------------|----------|--------|------------|----------|--------|
| | Gonorrhoea | Syphilis | Total | Gonorrhoea | Syphilis | Total |
| NSW | 3 517 | 304 | 3 821 | 3 535 | 645 | 4 180 |
| Vic. | 2 242 | 177 | 2 419 | 1 941 | 178 | 2 119 |
| Qld | 1 718 | 482 | 2 200 | 1 492 | 529 | 2 021 |
| SA | 2 114 | 305 | 2 419 | 1 855 | 484 | 2 339 |
| WA | 1 977 | 657 | 2 634 | 1 932 | 654 | 2 586 |
| Tas. | 172 | 2 | 174 | 165 | 2 | 167 |
| NT | 494 | 438 | 932 | 515 | 679 | 1 194 |
| ACT | 67 | 12 | 79 | 44 | 4 | 48 |
| Total | 12 301 | 2 377 | 14 678 | 11 479 | 3 175 | 14 654 |

Source: Statistical division, Department of Health, Canberra.

77. Table IV.2 shows cases actually notified according to the Department of Health, Canberra. There may be many more. The changing rate may reflect a change in reporting practice as well as a change in incidence.

Table IV.2 VD rate Australia 1971-75 (all cases of gonorrhoea and syphilis per 100 000 population)

| Year | Rate | Number (all forms) | % of syphilis cases |
|------|--------|-----------------------|------------------------|
| 1971 | 90.87 | 11 616 | 9.3 |
| 1972 | 94.32 | 12 254 | 9.9 |
| 1973 | 96.97 | 12 767 | 11.2 |
| 1974 | 110.30 | 14 755 | 14.8 |
| 1975 | 108.41 | 14 678 | 16.2 |

Source: Department of Health, Canberra.

78. Dr Barry Smithurst, Reader in Social and Preventive Medicine at the University of Queensland Faculty of Medicine, estimated to the Commission that:

Of the venereal disease notified in Queensland per year only 12-15 per cent is notified by private doctors and 85 per cent by hospitals and clinics . . . I would estimate only about one case in five is notified.⁶³

Dr Smithurst told us that 20 per cent of cases arose from homosexual contact.⁶⁴ Young people are a high risk group. Dr J. Billings told us that in Victoria venereal disease, together with measles, colds and flu, is the most widespread disease.⁶⁵

63. Evidence, p. 1600, Dr B. Smithurst.

64. *ibid.*, pp. 1602 ff.

65. Evidence, pp. 2846-67; Submission 1146, Dr J. J. Billings.

79. One of the main factors contributing to the spread of venereal diseases is ignorance of their causes, symptoms and effects. Schofield's study of young people in London reported that three-quarters of the boys and four-fifths of the girls who were sexually experienced would not have known the symptoms of venereal disease.⁶⁶ Ignorance is highest among the adolescent girls who comprise the group most at risk of catching and spreading venereal disease.⁶⁷ Women often do not develop symptoms of gonorrhoea but remain carriers.

Other sexually transmitted diseases

80. In addition to the major venereal diseases, there is another group of infections spread by sexual contact or behaviour, referred to as STDs—sexually transmitted diseases. These were the subject of a recent expression of concern by the National Health and Medical Research Council. They recommended that public health personnel give special attention to the delineation of groups at high risk in the population, and to related morbidity. It is highly desirable that special efforts be made to reach these target groups with education, information and treatment in a climate of tolerance.

81. Other sexually transmitted diseases include trichomoniasis, candidiasis, non-specific urethritis, genital warts, genital herpes and pubic lice. They have a range of such symptoms as vaginal soreness, pain, irritation, discharge and other symptoms such as pain at urinating, or painful intercourse. Certain situations predispose to infection, e.g.

... intercourse with an infected partner, use of antibiotics, pregnancy, wearing underwear which precludes aerobic circulation, oral contraceptives and diabetes.⁶⁸

82. Special attention should be given to the phenomenon of herpes simplex virus type 2 (HSV2). This is a viral condition for which there is no effective cure and it may have a link with cervical cancer.⁶⁹ The importance of honesty is paramount because anyone can be at risk with an infected partner, and no individual should be ignorant of risks to health in a sexual encounter. A pregnant woman who is subject to herpes simplex virus type 2 infection may have her child delivered by caesarian section to avoid serious infection of the child. Women should be aware of the consequences of HSV2 infection.

83. The NH & MRC has recommended that STDs be reported and uniform statistics kept; this would be separate notification from that for venereal disease. We would not press for this. It seems more important to treat the client, and to impress upon him/her the importance of telling his/her contacts of the infection and need for treatment. Public education is also much needed.

Programs to combat sexually transmitted diseases

Treatment, notification and tracing contacts

84. The emphasis of programs at present is on the identification, treatment and prevention of venereal disease. Basically similar measures are needed also for sexually transmitted disease of other kinds. An important part of any public campaign against

66. Schofield et al., pp. 93 ff.

67. Smithurst and Armstrong, Exhibit 103; B. S. Hetzel, *Health and Australian society* (Penguin, Melbourne, 1974), p. 85; studies by Smithurst (Brisbane) and Wood (Melbourne) confirm this group as being at risk.

68. J. Smibert, 'Vaginitis', *Australian Family Physician* 5 (1976).

69. L. Lasagna, *The VD epidemic* (University of Queensland Press, 1976), p. 38.

VD is to provide facilities for confidential treatment. There are special clinics in the capital cities. Persons attending clinics are asked to tell their partner or, in some cases, to give his or her name and address so that the person can be invited confidentially to attend for a check. It is not compulsory for people to give names—this might discourage attendance. Tracing of contacts can be made easier where clinics have the services of a full-time counsellor. Counsellors should also help, especially young people, with contraception and other problems.

Education

85. Another important part of the campaign is, of course, health education. Sex education programs for people of all ages need to give appropriate information on the prevention, transmission, recognition and treatment of venereal disease. In view of the early age at which some young people commence sexual experience, this information must be available to them. Medical education in aspects of VD is also important.

86. The AMA submitted that the medical profession has an important role to play in the education of young people:

. . . in the field of venereally communicable disease, teaching by a physician is important. A superficial knowledge of syphilis and gonorrhoea perhaps is possessed by many adults, but the stigma still attached to these infections prevents open discussion by most people.

. . . there is a complete lack of knowledge by the public of the minor venereal infections, such as pediculosis pubis, trichomonal vaginitis, venereal warts, non-specific urethritis, etc. Such diseases are widespread and must be expected to remain so with the frequent changing of sexual partners that sometimes occurs in young people. It is therefore considered that detailed instruction in the symptomatology and prevention of all such venereally transmitted infections should be carried out by a physician to all schoolchildren at the age of 14–15 years.⁷⁰

87. Any sexual hygiene program should not be confined to syphilis and gonorrhoea, but cover all sexually transmitted diseases. Some minor infections may be prevented by simple hygiene measures, and these should be a part of any course.

88. Education programs should include information about the use of condoms to reduce the spread of VD. A sexual ethic should be propounded in sex education programs which includes responsibility and honesty as a component of sexual relationships and encourages people to observe their own bodies for symptoms, and to advise partners in the event of such symptoms proving positive.

89. Public health education programs need to place information before people regularly, in the form of advertisements, posters and pamphlets, to ensure that people are informed or know where to go for information. These programs should not overlook the growing incidence of venereal disease among homosexuals.

90. Preventive campaigns should be run regularly in schools, in areas of association, in Aboriginal health services and wherever industry attracts large numbers of workers without steady partners. Public health education programs need to continue on a regular basis, and they should aim to avoid stigma or moral censure. The message should be clear. The advertisements 'Don't pass it on' and 'It's going around' by the Health Commission of NSW appear to meet this test. An extract from their pamphlet *Everything you've always wanted to know about VD* appears at Annexe IV.A. Another extract from a Western Australian publication 'How Clanger Molloy caught the clap

70. Submission 1101, AMA.

and gave it to his girlfriend!’ conveys similar information in a different style, designed for the young adolescent (see Annexe IV.B). In our view there is need to put more money into these programs and to look for new ways of getting the message across.

91. Some submissions suggested that there should be compulsory blood tests on marriage.⁷¹ We have considered this but we do not think that it would be justified. The group most at risk are not necessarily about to marry and many people marrying are not at risk. Clearly everyone who may be a carrier of venereal disease should have a test, but we do not think this should be compulsory on marriage. Pregnant women should be tested as a matter of routine.

92. The venereal disease clinics should offer contraceptive information and advice to patients.⁷² The value of the condom as some sort of preventive measure against VD should be stressed.

93. Administration of public health varies from State to State. We suggest that economies of scale could be gained by combining preventive campaigns, so that not one isolated problem but the range of health issues are constantly presented to the public. Not only sexually transmitted diseases, but also alcohol and drug abuse, road safety and hypertension can be presented as associated health problems, and public awareness maintained on all aspects. In line with such an approach, VD and other STD centres need not be separate reference centres, but one element in a community health centre. Each community health centre should include in its staff one experienced venereologist, and laboratory facilities for routine testing procedures. The client should not be submitted to unnecessary delay, and the clinic should be encouraged to operate as efficiently as do the present male and female clinics in cities. This would require increase in staff, expenditure and co-ordination required to train personnel and administer contact-tracing programs. Equally desirable is education for public responsibility, and for people to trace their own contacts. A positive approach to preventive health education that engenders responsibility is better than a disease-oriented policy.

71. Submission 1239, Michael Glass.

72. Commission of Inquiry into Poverty, third main report, *Social/medical aspects of poverty in Australia* (AGPS, Canberra, 1976), p. 147.

2. Fertility and fertility control

Introduction

1. Our terms of reference require us to consider:

... the provision, adequacy and effectiveness of existing family planning facilities, educational and activational information on family planning, and methods of evaluation of all family planning techniques.

We are concerned with all those factors which affect a person's ability to control his or her fertility, that is the ability to conceive children when they are wanted and to avoid conception at other times. We consider methods of contraception, provision of and access to services, factors affecting contraceptive use and reasons for contraceptive failure.

2. Most people now accept that parents should have a real choice as to the number and spacing of their children. Our submissions also demonstrate a common concern to avoid unwanted pregnancies. Some consider this to be a matter of personal autonomy and the opportunity to make choices. For some the issue is to avoid the pressure toward abortion. For still others it is a question of protecting the vulnerable child which may be born as a result of an unwanted pregnancy. Many submissions incorporate all of these concerns.

3. The range of views about fertility control is illustrated by the following points from submissions:

- (a) Family planning is a basic human right and the state has a duty to see that policies conform with these rights.¹
- (b) Family planning clinics will encourage pre-marital intercourse and permissiveness which will lower the priority of marriage and the family.²
- (c) Birth control should be used to help people to decide how many children to have, not to avoid childbearing for selfish reasons.³
- (d) There should be a compulsory limit on the number of children a family has.⁴
- (e) If we don't populate the world, bacteria or trees will; if we weaken ourselves with the pill grasshoppers will take over.⁵

The first three points broadly represent the range of views put to the Commission, whereas the last two are somewhat extreme positions.

4. Views are not unanimous on the means of promoting positive family planning and preventing or minimising unwanted pregnancies. There are some whose moral and religious beliefs reject pharmacological and mechanical means of preventing conception or of terminating pregnancy. For them the issue is simply stated—the acceptance of parental responsibility is the necessary corollary of sexual intercourse, and methods involving periodic abstinence from intercourse are the only acceptable means of limiting family size. Many who hold this view also reject termination of pregnancy except to save the mother's life.

1. Submission 210, WEL, Victoria.

2. Submission 283, Mr John Marron.

3. Submission 158, Lutheran Church of Australia, Commission on Social Questions.

4. Submission C311, confidential.

5. Submission 330, Mr John Barraclough.

5. For others, the main concern is the safety and effectiveness of methods of fertility control and the availability of contraceptive services. We have considered the limitations of present contraceptive technology and the social factors which affect people in their use of contraceptives. The side effects of contraceptive methods affect their level of use and these are also referred to.

6. We consider the role of government in ensuring that all have equal access to contraceptive services wherever they live and whatever their income level or ethnic origin. Certain groups in the community may be at special risk of having an unwanted pregnancy because of ignorance, unavailability of services, cost or other reasons. We consider whether contraceptive services and products should be more readily available to people who have special needs including young people.

7. Legal provisions affecting the provision of contraceptive services are reviewed to see whether they impede effective fertility control. Again there are conflicting views about the advertising and display of contraceptive products and about the use of paramedical personnel.

8. We start this chapter of our report with the proposition that everyone should know about and have access to information about sexuality, reproduction and methods of fertility control and should have equal access to the services and products suitable to their needs and beliefs.

Some important definitions

Fertility and fecundity

9. In common usage the word 'fertility' refers to the potential a woman or man may have to produce children. For example, a woman is frequently called fertile if it can be assumed or demonstrated that she ovulates regularly; a man is called fertile if an abundance of live spermatozoa can be found in his seminal fluid. As such, fertility is sometimes confused with the concept of virility which, however, implies sexual potency and stamina.

10. Common usage, however, differs from the meaning of the word fertility as defined by demographers and as used, increasingly, by family planning and other health personnel. In this case:

... 'fertility' refers to children born, while 'fecundity' refers to the physiological capacity to bear children.⁶

We adopt and use this definition in our report. Thus, a woman's fertility and a nation's fertility rate are measured by counting the number of live births occurring to the woman or the nation respectively.

Fecundability

11. Fecundability means the probability of conception occurring to a group of women of defined age or parity. The rate of fecundability means the monthly probability of conception per 100 women.

Fertility control

12. The Commission uses the term 'fertility control' to mean the regulation of the number of births a woman has and not simply the number of pregnancies she has. All methods of preventing births may be correctly included under this definition, and it is for this reason that abortion has been included with methods of contraception when speaking of fertility control.

6. E. Pohlman, *Psychology of birth planning* (Schenkman, Mass., 1969), p. 10.

Contraception

13. The term 'contraception' is used in this report to mean those methods of fertility control which prevent conception or implantation.

Family planning

14. The term 'family planning' has been widely used in Australia and elsewhere, and is well understood as referring both to the services of the family planning clinics and to methods of prevention of conception. The term family planning was adopted in the UK in substitution for 'birth control' to emphasise the positive aim of 'children by choice not by chance'. It seems to imply a conscious act of forward thinking about the number and spacing of children forming a family unit. In this sense the idea of family planning is widely accepted and it is an important aspect of fertility control. In this report we do not in general use the term family planning as a general description of contraceptive services. The issues arising in relation to contraception are wider than may be understood by the use of the term family planning—for example the provision of services to single people and to teenagers. To look at the subject in too narrow a focus may obscure the issues and make it difficult to determine policy goals. We therefore use the term contraception and contraceptive services, in preference to family planning, to indicate that part of fertility control which relates to the prevention of conception.

Abortion

15. Abortion is defined in this report as the termination of a pregnancy before the foetus has become viable. As such, it is a means of fertility control. The issues to which it gives rise differ in some important respects from those relating to contraception and are considered in a separate chapter.

Methods of contraception and their evaluation

16. Our terms of reference require us to report on 'methods of evaluation of all family planning techniques'. In this section we describe current methods of contraception and discuss problems of evaluation from several viewpoints: their effectiveness in preventing pregnancy, their 'naturalness', and their safety in terms of morbidity or mortality. The social, economic and personal factors which affect the level of use and continuity of use of contraception are considered in the section which follows (Contraceptive use).

Methods of contraception

17. We set out here the methods of contraception in use in Australia. They are then classified according to different criteria and some information about the level of use of different methods is presented.

18. In the 1930s Dr Marie Stopes wrote in the preface to her handbook on birth control:

By the intelligent use of scientific birth control a woman takes into her own hands the power to control not only the number of children she desires to have, but the times and seasons at which they are conceived. The open and intelligent use of such control by mankind marks a new human epoch, the greatest the world has yet known.⁷

The main method which she then advocated was the diaphragm, in its various forms. She also analysed other methods then in use and expressed her own views about such methods as the condom, withdrawal and the safe period, as well as describing some

7. Marie Stopes, *Birth control today. A practical handbook for those who want to be their own masters in this vital matter* (3rd edn, Watt, London, 1935), p. 5.

makeshift methods, including olive oil, the bath sponge and even coughing. Today the emphasis is on chemical methods, though there is some evidence of a growing interest in the IUD and in sterilisation. The choice of method depends on a number of personal and social factors.

Oral contraceptives

19. The contraceptive pill contains one or a mixture of synthetic steroid hormones. When taken by mouth these hormones are absorbed into the bloodstream. Their mode of action is to suppress ovulation and/or to cause changes in the reproductive system which make fertilisation or implantation improbable. There are three types of oral contraceptive pill in current use:

- (a) The combined pill. This contains a fixed combination of synthetic oestrogen and progestagen, which is taken for 21 consecutive days out of 28. During the 'week off', menstrual-type bleeding occurs. This type of pill is regarded as the most effective in preventing pregnancy.
- (b) The serial or sequential pill. In this, the ratio of oestrogen to progestagen taken each day varies in a way which mimics the sequence of hormone production in the natural menstrual cycle. This type of preparation is less effective in preventing pregnancy than the combined pill.
- (c) The progestagen-only pill (or 'mini-pill'). This contains only a small dose of progestagen. Ovulation may take place, but these pills cause changes in the female reproductive system which make fertilisation and implantation unlikely. The pregnancy rate is higher for this kind of pill particularly if one pill is forgotten. This preparation does not usually suppress lactation.

The oral contraceptive pill is the method of contraception most widely used in Australia. Various side effects and complications have been listed for this method. Some of these side effects are regarded as beneficial; some have been monitored though their effect upon health is not known; some are on rare occasions serious or fatal. The safety of the pill is discussed below.

Intra-uterine devices

20. Small devices inserted into the uterus, they are usually made of polythene but may be latex, gold, silver or steel. Some have copper wire wound around them and trials are being conducted with devices yielding a slow progestagen release. The device may be inserted with or without local anaesthetic in the surgery and may be left in place for 1 to 5 years depending on the device. The action of the IUD is not completely understood. It is thought to cause changes in tubal transport and the uterine lining which impede implantation. The pregnancy rate is highest in the first months after insertion and decreases with time. The IUD has more limited use than the pill since it is not well tolerated by all women, particularly those who have not had children, due to increased bleeding and uterine cramping.

The diaphragm

21. The diaphragm is a thin rubber dome mounted on a circular base containing a metal spring. It is fitted over the neck of the uterus or cervix prior to intercourse where it acts as a barrier to sperm entering the uterus. It should be left in place for a minimum of 6 to 8 hours thereafter. Before insertion the diaphragm may be smeared with spermicidal jelly or cream which effectively kills sperm as well as forming a protective seal around the rim of the diaphragm. Initially the diaphragm is fitted by a trained practitioner. Except for rare allergic reactions to rubber or spermicides, this method causes no side effects and has a high theoretical effectiveness. In practice the pregnancy rate is increased by failure to use the diaphragm at every intercourse and failure to insert it correctly so that the cervix is covered.

Condoms

22. This is another barrier method which prevents sperm from entering the vagina. The condom is a thin latex rubber sheath which covers the erect penis. It must be put on prior to sexual contact and functions by collecting the sperm. The pregnancy rate is low especially when used in conjunction with spermicides.

Withdrawal (coitus interruptus)

23. This is a male method whereby the penis is withdrawn from the vagina just prior to ejaculation to prevent sperm from entering the vagina. Failure results from delayed withdrawal and possibly because some sperm are lost from the penis prior to ejaculation.

Spermicides

24. These are chemical substances which interfere with the motility of the sperm and render them ineffective. They are available in foam, cream, jelly or suppository form. Used alone they are less effective in preventing pregnancy, because there is nothing to hold them around the entrance to the cervix, the point of entry to the uterus. They are more effective when used with the diaphragm or with the condom.

Periodic abstinence methods

25. These methods prevent pregnancy by the avoidance of intercourse on those days of the female cycle when fertilisation is possible. Spermatozoa may live in the female uterus and fallopian tubes for up to 5 days. Intercourse must therefore be avoided for several days prior to ovulation and for 24–48 hours thereafter since the ovum may live for this period of time. The minimum period of abstention required is 7 days. Best results are achieved if intercourse is avoided for the entire pre-ovulatory phase of the menstrual cycle. There are three ways in which ovulation or approaching ovulation may be estimated.

- (a) *Calendar method:* The woman must estimate the first day of her next period and subtract 14 days from that day to estimate the day of ovulation. Abstinence must then be observed for at least 5 days prior to ovulation and 2 days thereafter. The method is unreliable for women with irregular cycles.
- (b) *Temperature method:* Ovulation may be estimated by recording a woman's basal body temperature. A small rise in temperature of 0.2°C or more occurs just after ovulation has taken place. If a woman has a regular cycle she may predict her day of ovulation by reference to previously monitored cycles. However, if her cycle is irregular this is not possible and she has no advance warning of ovulation. The temperature rise may also be obscured by other factors causing a rise in temperature.
- (c) *Ovulation method:* The approach of ovulation is thought to be signalled in most women by secretions of mucus in the vagina, the nature of this mucus changing as ovulation approaches with a peak symptom denoting ovulation. The mucus undergoes changes over several days and the woman observes and interprets these changes. Abstinence is observed in the presence of the mucus symptoms, for 2 or 3 days after ovulation and during menstruation. Intercourse prior to ovulation is permitted on every alternate day only during apparently safe days so that mucus symptoms are not obscured by the presence of seminal fluid. For greater accuracy the method is sometimes combined with the temperature and calendar methods and called the 'sympto-thermal method'.

26. These periodic abstinence methods have no chemical or mechanical side effects. Their effectiveness has been disputed. In addition, some people maintain that periodic abstinence according to a regimen of calendar days, mucus or temperature symptoms may have adverse emotional effects.

Injectibles

27. Injections of slow release progestagens may be given at 3- or 6-monthly intervals to achieve the same effects as the pill. The main problems associated with these injections are the disturbance of the menstrual cycle and the delay in return to fecundity after the injections are discontinued. Because of these side effects, the substances in question have not been approved in Australia for contraceptive purposes though they are used in some other countries. The advantage of the injection is that, once given, the woman does not have to remember to do anything except present for the next injection. The disadvantages are that, once given, any side effects persist for the duration of the effectiveness of the injection or longer.

The 'morning after' pill

28. The 'morning after' pill is a high dose of oestrogen given within 72 hours of intercourse to prevent implantation. The potential of this dosage to damage the foetus is such that if the pill is unsuccessful, termination of the pregnancy is advised. Side effects of nausea and bleeding frequently occur.

Female sterilisation: tubal ligation

29. The fallopian tubes in the female are cut, cauterised or tied to prevent the ovum moving down the tube or the sperm moving up the tube. The operation may be performed in a number of ways, either abdominally or vaginally. Morbidity of the operation varies with the method of operation. Some side effects, such as heavy menstrual bleeding, have not been fully investigated. The operation is not usually reversible though cases have been reported of births after microsurgical reunion of the fallopian tubes.

Male sterilisation: vasectomy

30. The vas deferens, two tubes which transport the sperm before they join the seminal fluid, are cut and tied. The operation is brief and is usually performed on an outpatient basis. Some claim that rare side effects occur. A few surgeons report successful reunion of the vas; fertility is not necessarily restored. Experiments in frozen semen storage have occurred in the United States.⁸

Future possibilities

31. A number of possibilities are being investigated for future contraceptive use. These include the male pill, the once-a-month pill, prostaglandin pessaries, 400-day implants, slow release progesterone inserted as an IUD, the coital pill (taken at the time of intercourse) and immunisation.

Classification of methods

32. Methods of fertility control can be classified by a number of criteria.

Mode of action

33. (a) Prevent fertilisation: Oral contraceptives; injectibles; condoms; diaphragms; abstinence methods (calendar, temperature, ovulation); jellies, foams; withdrawal (coitus interruptus); sterilisation.

8. 'Vasectomy reversibility—a status report', *Population Reports*, Series D, 3 (1976).

- (b) Impede implantation: IUD; 'morning after' pill.
- (c) Interrupt gestation: Menstrual extraction; termination.

Time span of action

- 34. (a) Permanent: Sterilisation.
- (b) Short or medium term: Oral contraceptives; IUDs; injectibles.
- (c) Coitus specific⁹: Condoms; diaphragms; withdrawal (coitus interruptus); abstinence methods.

Source of method

- 35. (a) Currently requires a doctor's prescription: Oral contraceptives; injectibles; diaphragms need to be fitted by a doctor.
- (b) Procedure must be performed by a medical practitioner: IUD insertion; menstrual extraction; termination; sterilisation.
- (c) Does not require medical advice but may require other instruction: Any method of abstinence (calendar, temperature, ovulation); condoms; foams, jellies; withdrawal (coitus interruptus).

Level of use of contraceptives

36. The main information about the level of use of different methods of contraception in Australia is derived from a survey of married women in Melbourne.¹⁰ The sample is not fully representative of sexually active Australian women as it excludes all single, divorced, separated and widowed women. The data were collected in 1971 and the pattern of use may have changed since then; other sources of information suggest that the use of oral contraceptives and IUDs has increased. Table IV.3 shows the methods of contraception used in 1970-71 by married women under 45. It also includes the proportions of women who were pregnant, wanting pregnancy or sterile.

Table IV.3 Methods of contraception, 1970-71

| Method of contraception | % |
|-------------------------|------|
| Pill | 26 |
| IUD | 6 |
| Condom | 5 |
| Diaphragm | 2 |
| Other | 3 |
| Withdrawal | 13 |
| Rhythm | 8 |
| Nothing used | 4 |
| Want pregnancy | 5 |
| Pregnant | 8 |
| Sterile | 20 |
| Total | 100 |
| Number | 1977 |

Source: Donald R. Lavis, 'Oral contraceptives in Melbourne, 1961-71', Australian Family Formation Project, Monograph no. 3, p. 91.

- 9. i.e. methods of fertility control which must be thought of or remembered every time intercourse is contemplated.
- 10. J. Caldwell et al., 'Australia: knowledge, attitudes and practice of family planning in Melbourne, 1971', *Studies in Family Planning* IV, 3 (1973), p. 49; J. Caldwell & H. Ware, 'The evolution of family planning in Australia', *Population Studies* XXVII, 1 (1973), p. 309.

The accompanying report points out that of those not pregnant, planning pregnancy or sterile, 38 per cent were using oral contraceptives.

37. A number of demographic factors affect the level of use. For example, withdrawal is used mainly by southern European migrants of Orthodox religion while rhythm is practiced mainly by Catholics.¹¹ The proportion of those using no method or using rhythm was higher among those with more children.¹² Further information is set out in the section on contraceptive use. Sterilisation is considered in the section on the law and contraception.

Evaluation of methods

38. In deciding what method of contraception to use people need to know how effective a method is, how easy it is to use, its risks and side effects, its cost, whether it is aesthetically acceptable, how to obtain supplies and its ethical acceptability.

39. The choice is influenced by one or more of those factors, and by the age, stage of life and number of children of the couple. For example, couples who want further children, or who want only to defer or space new births, may choose a method which would not be considered satisfactory by a couple whose family is complete.

40. The social factors are considered in the next section. Here we are concerned with the criteria of effectiveness, naturalness and safety.

Effectiveness

41. An important criterion for a method of contraception is its effectiveness in preventing pregnancy. Because the effectiveness of a method depends on the user's motivation to use the method regularly and properly, it is usual to distinguish between theoretical effectiveness and effectiveness in practice.¹³ Theoretical effectiveness is estimated on the basis of perfect use without omissions or error as if in laboratory conditions. These conditions cannot be actually attained but are inferred from other factors including the performance of successful users. Effectiveness in practice is the rate of effectiveness achieved by actual users and takes into account many social factors affecting consistency of use. These factors may also lead to discontinuation of a method and this, too, must be considered. Here we are concerned with theoretical effectiveness.

42. In reviewing the published research available in 1971, Tietze in the United States estimated the theoretical effectiveness of the various methods of contraception, as shown in table IV.4.

43. Two 1974 reports estimate effectiveness without distinguishing between theoretical effectiveness and effectiveness in practice. Some allowance for user motivation is made in the range of rates. Much of the variation in these rates (see table IV.5) is also due to difficulties of research design and the impossibility of knowing to what extent the methods were correctly and consistently used. There are difficulties in controlling such variables as fecundity and experience.

11. Donald R. Lavis, 'Oral contraception in Melbourne, 1961-71', Australian Family Formation Project, Monograph no. 3, p. 91 (see tables, pp. 99ff).

12. *ibid.*, pp. 95-6; especially among those with six children or more.

13. C. Tietze, 'Ranking of contraceptive methods by level of effectiveness', *Advances in Planned Parenthood* 6, 1 (1971), p. 117.

Table IV.4 Estimated theoretical effectiveness

| Method | Pregnancy rate per 100 women per year |
|---|---|
| Female sterilisation | 0.04 |
| Male sterilisation | 0.15 |
| Oral contraceptives— | |
| combined preparations | 0.07 |
| sequential preparations | 0.34 |
| Intra-uterine devices (in the first year of use; rates decline in subsequent years) | 1.5 –3.0 |
| Condom and diaphragm | 1.5 –3.0 |
| Low dosage continuous progestagen oral contraceptive | 2.3 |

Source: 'Ranking of contraceptive methods by levels of effectiveness', *Advances in Planned Parenthood* 6,1 (1971), p. 117.

Table IV.5 Estimated effectiveness

| Method | Pregnancy rates per 100 women per year | |
|------------------------|---|-----------------|
| | Source A | Source B |
| Sterilisation | 0.1 | not given |
| Oral contraception | 0.2 | 0–1.3 |
| Intra-uterine device | 1–5 | 2–3.3 |
| Condom | 3–15 | 7–28 |
| Diaphragm and jelly | 10–20 | 4–35 |
| Coitus interruptus | 15 | 1–38 |
| Calendar rhythm | 30–40 | 'safe period' } |
| Ovulation, temperature | 7–21 | 0–38 } |
| Spermicides | 20 | 12–43 |
| No contraception | 70 | not given |

Source A: J. Leeton, *All about birth control* (Nelson, Melbourne, 1974).

Source B: *Report of the Committee on the Working of the Abortion Act*, vol. 1 (HMSO, London, 1974), p. 167.

44. The intra-uterine device is not subject to some of the variables mentioned. Nevertheless its effectiveness varies to some degree with the skill of the doctor inserting the device.¹⁴ Doctor skills are also factors in effective sterilisation, diaphragm fitting and oral contraceptive prescription.¹⁵

45. Effectiveness also varies with the quality of instruction; this is particularly true for the periodic abstinence methods and for correct diaphragm insertion. The effectiveness achieved by reliable users is the criterion by which the effectiveness of a method should be judged, since true theoretical effectiveness makes no allowance for ordinary human qualities such as forgetfulness nor for intervening factors such as illness which may make the method ineffective or difficult to adhere to. Effectiveness rates usually reflect the best that a group of motivated people can achieve in the varying circumstances of their lives.¹⁶

14. B. Simcock, Letter to editor, *MJA*, 3 April 1976.

15. H. Lehfeldt, 'Psychological factors in failure', in M. S. Calderone (ed.), *Manual of family planning and contraceptive practice* (Williams & Wilkins, Baltimore, 1970).

16. C. Tietze, J. Bongaarts & B. Schearer, 'Mortality associated with the control of fertility', *Family Planning Perspectives* 8, 1 (1976), p. 7.

46. The effectiveness rate of a particular method of contraception is not constant across a population. Some people can achieve better results with one method than with another, regardless of the rate of theoretical effectiveness. Some are unable to use any method effectively. Sterilisation is, of course, unaffected by user failure.

47. It is generally accepted that for motivated users the pill, the IUD and condoms and diaphragms are effective methods of preventing pregnancy. Spermicides alone and withdrawal are less reliable even when used by those with high motivation. There was no dispute concerning the evaluation of the effectiveness of these methods in submissions to the Commission.

48. The periodic abstinence methods (calendar rhythm, temperature and ovulation) were also regarded by many as less effective. While there is little dispute about the relative ineffectiveness of calendar rhythm and temperature methods, our submissions reflected considerable dispute about the theoretical and actual effectiveness of the ovulation method.

49. Dr J. J. Billings of Melbourne, a pioneer of the ovulation method, made a submission and gave evidence in support of the method. His view is that once the cervical mucus pattern can be correctly identified by the woman, and provided that intercourse is avoided on the days when the mucus pattern indicates fecundability and for 2 or 3 days following ovulation, pregnancy is most unlikely to occur. He considers that most pregnancies associated with the ovulation method occur when a woman has not understood her mucus pattern or when a couple have decided to abandon the method.

This means that in any survey of couples who have commenced the use of natural methods, a number of pregnancies will be observed consequent upon abandonment of the method.¹⁷

Annexe IV.D sets out instructions for the use of the method.

50. A confidential submission claimed that the ovulation method was highly reliable and that it is used by 22 000 couples taught by correspondence and personally.¹⁸

51. Other submissions queried the effectiveness of the rhythm and ovulation methods of contraception.¹⁹ Professor J. Leeton agreed that ovulation is a very good method in theory but said it had a failure rate of 20 per cent.²⁰ Ms Katherine Betts drew attention to difficulties in distinguishing between those who abandon the method intending to become pregnant and those who do so under the pressure of sexual excitement or because the period of abstinence is too long.²¹ She referred to research on the method carried out in Tonga which suggested a failure rate of 25.4 pregnancies per 100 women.²²

52. In reply to Ms Betts's submission, Dr Billings mentioned that the World Health Organisation has planned a multi-centre trial of the ovulation method in some developing countries. He also pointed out that the method is inexpensive and that

17. Submission 1146, Dr J. Billings.

18. Submission C206, confidential; see also Submissions 510, Fr John Swann, Catholic FP Centre; 402, St Joans International Alliance, Queensland (on the safe period).

19. Submissions 148, FPA SA; 556, Cole & Beighton; Evidence, p. 798, Prof. J. Leeton.

20. Evidence, p. 805, Prof. J. Leeton.

21. Submission 68, Ms Katharine Betts.

22. Weissmann, Foliaki, Billings & Billings, 'A trial of the ovulation method of family planning in Tonga', *The Lancet*, 14 October 1972, pp. 813-6.

there are millions of people around the world who will use no other method. On the effectiveness of the method he commented:

All natural methods leave undisturbed the fertility of both the husband and the wife. In many instances they will depart from the use of this method from time to time, with the occurrence of pregnancy as the result. Their right to do so is a matter of human freedom, not an indication of the reliability of the method. The attitude of regarding these pregnancies as an indication of weakness of the method requires further examining.²³

53. The effectiveness of the ovulation method depends on the ability of the woman to identify her pattern of ovulation and on the motivation of the couple to abstain during the relevant period.

54. During the term of the Commission a study of the theoretical and use-effectiveness of the ovulation and sympto-thermal methods has been under way at St Vincents Hospital in Sydney, funded by a Commonwealth Department of Health research grant.²⁴ The study began in 1975 and has followed the progress of some 1500 couples attending more than sixty Natural Family Planning clinics and centres in Australia. An additional 150–200 couples receiving instruction by correspondence are also being surveyed. Approximately 35 000 menstrual cycles are being reported on retrospectively and about 20 000 are being studied prospectively. At the time of writing this report, final results from this survey are not available but some preliminary analyses of data have been made available to us.

55. Data from the retrospective study suggest that only 25 per cent of women are able satisfactorily to identify and interpret mucus symptoms regularly and consistently enough to predict with confidence their times of fertility and infertility. A further 50 per cent of women appear able to identify and interpret mucus symptoms in some cycles but not in others. The remainder seem unable to identify and interpret mucus symptoms in any cycle. Such an outcome does not primarily appear to be due to the quality of instruction received, but rather to the variability of the mucus symptoms and the capacity of women to identify and interpret a physiological phenomenon within a range of differing social, emotional and behavioural contexts.

56. The study suggests the possibility of a 5-day sperm survival. Such a finding has specific implications for these methods, in the pre-ovulatory phase. If the mucus symptoms are not detected early enough, or do not last long enough, intercourse may take place too close to the time of ovulation and pregnancy may result. Preliminary analysis of the study indicates that most unplanned pregnancies reported have occurred as a result of intercourse in the pre-ovulatory phase. The data so far indicate a pregnancy rate of 15–20 per 100 women per year for the ovulation method where intercourse occurs in both phases of the cycle. The sympto-thermal method appears to possess a slightly lower pregnancy rate in both phases. Where intercourse is confined to the post-ovulatory phase, the risk of pregnancy is very significantly reduced. Where this phase only is used both methods appear to produce pregnancy rates of 3–5 per 100 women per year.

57. Improved rates could also be achieved by using the condom or diaphragm until after ovulation has occurred as monitored by mucus and/or temperature symptoms. This could be unacceptable to many who use the ovulation or sympto-thermal methods for religious reasons. Many others, who are unable or unwilling to use the pill, IUD or periodic abstinence alone, could however, with adequate instruction,

23. Submission 1146, Dr J. Billings.

24. Commission correspondence, Confidential file S239.

effectively use such a combination. The ovulation method requires the co-operation of both parties. While couples who agree about this method of contraception and who are also highly motivated to avoid pregnancy may successfully be able to avoid intercourse on the fertile days, other couples may not.

58. The St Vincents survey shows that the use of contraceptive methods based upon periodic abstinence can enhance interpersonal relationships for successful users. Other evidence suggests that prolonged abstinence, lack of confidence in the method chosen and fear of unwanted pregnancy can cause stress affecting a couple's relationship. The results of the St Vincents survey should be studied carefully when they become available.

59. People using the ovulation method should be informed of the factors that determine the effectiveness of the method in comparison with other methods. While this method, or the sympto-thermal method, may be the only method acceptable to many on religious or other grounds and may be preferred by some over mechanical or chemical methods, its effectiveness is open to doubt and we do not consider that it should be promoted to replace other methods. The ovulation method may be useful in assisting couples who wish to begin a pregnancy to determine the optimum time for intercourse.

Naturalness

60. The periodic abstinence methods are sometimes called natural because they do not interfere with sexual intercourse or the normal physiological processes of the body. One Catholic Womens League wrote:

Our objections to artificial contraception, whether chemical, surgical or other, arise from their unnatural nature which makes us feel that to counsel their use is deleterious to the human person either psychologically or physiologically, *or both*, and so outside proper medical practice.²⁵

61. This objection applies to chemical methods, to mechanical methods, such as the condom and diaphragm, and to such methods as withdrawal which some regard as natural because it involves no device or chemical. The argument asserts that when intercourse is allowed to take place it should not be restrained by any contraceptive act or device, and thus fertility control must be achieved by periodic abstinence. The argument is based not merely on the possible harmful effects of other contraceptive methods but also on the value of unprotected intercourse. A number of submissions asserted further that periodic abstinence was not only natural but also beneficial:

The sexual discipline imposed by necessary abstinence gives security to the marriage and promotes the development of sexual maturity²⁶ . . . men and women should learn to become sexually mature by abstinence before marriage . . . the method which requires self-control teaches people to become responsible. Once sexual pleasure is pursued without responsibility for parenthood, the whole creative partnership between men and women is reduced to genital communication.²⁷

62. The benefits of cyclically determined abstinence are in dispute, however. For example, a number of other submissions pointed out that the high incidence of sexual difficulty observed in Australia today is associated with the numerous social constraints on sexuality and the direct linking of sexuality with parenthood.²⁸ Moreover,

25. Submission 312, Catholic Womens League, North-western region, Archdiocese of Canberra- Goulburn; see also Submission 402, St Joans International Alliance, Queensland.

26. Submission 586, Catholic Womens League, NSW.

27. Submission 1146, Dr J. Billings.

28. e.g. Submission 433, Dr R. Farmer.

since periodic abstinence requires considerable instruction, motivation and day-to-day diligence, it must be described as a learnt rather than a natural behaviour. As a method of contraception it interferes with the spontaneity of sexual activity and leads to denial or suppression of libido in the pre-ovulatory phase. It is acknowledged by proponents of the ovulation method that 'when the mucus is present, it frequently causes increased sexual inclination.'²⁹

63. We do not consider that any method of contraception can truly be called natural.

Safety

64. The safety of a method of fertility control has conventionally been discussed in terms of the incidence of physiological and psychological diseases (morbidity) and death (mortality) caused by the method. The morbidity and mortality of the oral contraceptive and the IUD, for example, have been extensively investigated in these terms. Working from this premise, a number of submissions asserted that methods of contraception requiring no chemical or surgical intervention have no physiological or psychological side effects, and therefore no morbidity or mortality rates. Although these submissions usually referred exclusively to periodic abstinence methods, such methods as withdrawal, condom and diaphragm might also be included under such a heading. Allergic reactions to spermicides and rubber are extremely rare and there is no definitive indication of psychological morbidity for any of these methods although these cannot be ruled out.

65. In considering whether one method is safer than another, account can also be taken of the risks which may arise from the failure of the method. Each method of contraception has a pregnancy rate based on its theoretical effectiveness and on its effectiveness in practice. Pregnancy rates refer to the number of pregnancies which would be experienced by 100 women using a method of contraception for one year providing the method is rigorously adhered to. Higher pregnancy rates are usually found, however, in populations not rigorously instructed and monitored for research purposes and these vary with the ease of using the method, the age, parity (i.e. the number of live births) and socio-economic status of the woman and her motivation to avoid pregnancy.

66. For each method of contraception, therefore, the safety of the method depends on:

- (a) physiological and psychological consequences associated with the method (morbidity and mortality);
- (b) the risk of pregnancy and the morbidity and mortality associated with:
 - (i) pregnancy and childbirth;
 - (ii) abortion.

Estimates of safety which take these factors into account are purely theoretical since they combine the results of separate studies. The extent to which the risks of pregnancy so assessed would affect any individual's assessment of the safety of a method may depend on the acceptability to that person of pregnancy if contraception fails.

Mortality

67. The mortality associated with a method of contraception is the deaths that occur from the method itself or from the pregnancy, childbirth or abortion if the method is unsuccessful. The incidence of mortality due to either source is low although not negligible.³⁰

29. See Annexe IV.D, 'A note for teachers', para. 2.

30. Tietze et al., 1976, p. 6.

68. It is possible to calculate comparative mortality rates for fertility control methods which take into account both the mortality rate of the method and the mortality rate associated with the risk of pregnancy. A study of this kind has been made by Tietze, Bongaarts and Schearer for the pill, IUD, tubal sterilisation, condom and diaphragm. In their model for this study, they make assumptions based on existing data about the effectiveness of each method. They also assess published research data for the mortality rates used in the model. These are summarised in table IV.6.

Table IV.6 Mortality associated with pregnancy and childbirth, induced abortion, use of oral contraceptives and IUDs, and tubal sterilisation, by age of women

| Age group | Pregnancy and childbirth* | Induced abortion† (first trimester) | Oral contraception‡ | IUDs§ | Tubal sterilisation§ |
|-----------|---------------------------|-------------------------------------|---------------------|-------|----------------------|
| 15-19 | 10.8 | 2.3 | 1.3 | 1.0 | na |
| 20-24 | 8.5 | 1.9 | 1.3 | 1.0 | na |
| 25-29 | 12.1 | 1.9 | 1.3 | 1.0 | 10.0-20.0 |
| 30-34 | 25.1 | 4.2 | 4.8 | 1.0 | 10.0-20.0 |
| 35-39 | 41.0 | 9.2 | 6.9 | 1.0 | 12.5-25.0 |
| 40-44 | 69.1# | 10.1 | 24.5 | 1.0 | 15.0-30.0 |

* Ratio per 100 000 live births.

† Ratio per 100 000 first trimester abortions.

‡ Ratio per 100 000 users per year.

§ Ratio per 100 000 operations at beginning of age interval.

The mortality ratio for all women aged 40 years or more was 78.5 per 100 000 live births.

Note: na = not applicable.

Source: Teitze et al., 'Mortality associated with the control of fertility', *Family Planning Perspectives* 8, 1 (1976), p. 7.

69. Further tables showing mortality rates for methods of fertility control and explanatory notes are set out at Annexe IV.E.

70. The theoretical model (see Annexe IV.E) is based on the death rates associated with oral contraceptives, IUDs, traditional methods (condom and diaphragm), the pregnancy rates of those methods and the death rates of abortion, pregnancy and childbirth. It compares the risks of death arising from:

- (a) the method of contraception (the condom and diaphragm have no risk of death);
- (b) pregnancies and births arising from method failure or non-use of any method (the risk is highest with the least effective methods);
- (c) abortion where pregnancy occurs due to method failure or no method.

The model also assumes the availability of low risk abortion.

71. The higher the effectiveness of the method, the lower the risk of death from childbirth and delivery. The tables in the model show higher levels of effectiveness than may be found in Australia; lower levels would result in higher risks from death from pregnancy.

72. The authors conclude:

This analysis confirms the very low level of mortality associated with all major reversible methods of fertility control—the pill, IUD, condom and diaphragm and abortion, used singly or in combination—compared with the risk of death from pregnancy and childbirth when no fertility control method is used (with the one notable exception of pill use after age 40).

73. The authors state that, although the data are derived from the United Kingdom and the United States, the model is applicable to developed countries. The maternal mortality rates for Australia and the USA are similar.³¹

74. The main implications of this analysis are these:

- (a) Uncontrolled fertility incurs a greater risk of mortality from pregnancy and childbirth than the use of any efficient method of contraception, except the pill by women who are over the age of 40.
- (b) The risk of death associated with the use of the IUD or pill is lower than the risk of death from uncontrolled fertility or abortion (except in the case of women over 40 taking the pill, when it is higher).
- (c) Abortion used as a sole method of fertility control reduces the risk of mortality associated with pregnancy but not as effectively as the use of contraception.
- (d) The risk of mortality is reduced if the method of contraception is followed by early abortion when the method fails. The least risk of mortality is incurred by women who use condoms or the diaphragm, and abortion when these methods fail.

75. As mentioned, the study is a theoretical model which assumes that early, safe abortion is available. It does not take into account how willingly an individual is prepared to accept the mortality risks of pregnancy, childbirth, abortion or contraception. To do so would go outside the model.

76. We consider however that women are entitled to know about the risks they run both in using contraception and in becoming pregnant, and that the risks of pregnancy vary significantly from method to method. They should be informed of the risks of pregnancy which may arise from method failure.

Morbidity and side effects

77. Because the risks of mortality seem remote and unlikely, the issue of morbidity (illness or disease) associated with methods of contraception was seen as more important in a number of submissions. Writers on the morbidity (or side effects) of contraception frequently include psychological disorders, such as depression, which appear to be directly associated with the use of the method.

78. The morbidity associated with pregnancy and childbirth or abortion is rarely included in a consideration of the morbidity associated with a method of contraception. Since all methods of contraception have a pregnancy rate, however, consideration of the risks of morbidity, physiological and psychological, from pregnancy and its consequences due to the failure of the method should not be completely ignored.

79. A few submissions asserted that the risk of morbidity due to the use of oral contraceptives, IUDs and sterilisation procedures was sufficiently serious to warrant their substitution by other methods. Dr Herbert Rattner stated in evidence to the Commission:

. . . we now have two birth control things on the market, the pill and the intra-uterine device known as the coil, which never could have cottoned on in the market given if we knew then what we now know. These are the only dangerous forms of birth control that have ever existed in the history of mankind . . . [speaking of the pill] this is chemical warfare against women and the world. The least governments can do is to see that, as we try to in the United States, a woman gets to know the serious and many complications associated with the pill—they run anywhere from 30 to over 100—it is a pill that involves

31. National Health and Medical Research Council, *Report on maternal deaths in Australia 1970–72* (AGPS, Canberra, 1976), p. 8.

powerful synthetic chemicals imitating natural hormones but baffling many, and the mechanisms of nature, because it is synthetic and it is a barrier and it results in a long, long list of complications . . . It introduces about a 30 per cent depression rate. It introduces sterility of about 3 per cent.³²

80. Several other submissions also dealt with the side effects and/or morbidity of these methods of contraception.³³ With regard to oral contraceptives Dr Billings raised the issue of the danger of thrombotic disease, foetal deformities, depression, uterine fibroids, migraine, asthma, cardiac and renal dysfunction, disorders of calcium and phosphorus metabolism. He also quoted the following adverse reactions:

. . . which have been reported in women taking oral contraceptives . . . nausea, vomiting, abdominal cramps, breakthrough bleeding, breast changes (tenderness, enlargement), changes in menstrual flow, cervical erosion and changes in cervical secretions, amenorrhoea during and after treatment, anovulation after treatment, cholestatic jaundice, pruritis, rash (allergic), photosensitivity, alopecia, chloasma, erythema multiforme, erythema nodosum, haemorrhagic eruption, hirsutism, headache, migraine, dizziness, drowsiness, changes in libido, changes in appetite.

81. He also noted that pain, bleeding, sepsis and perforation of the uterus are the main risks attached to IUD use. After tubal ligation, he states:

. . . there may be the development of gynaecological disorders, especially haemorrhage, severe enough in some cases to require hysterectomy.³⁴

82. The submission from the Knights of the Southern Cross drew attention to the metabolic changes that have been observed to occur as a result of taking oral contraceptives. These were: depression, cancer (breast and endometrial), thrombotic disease, high blood pressure and sterility.³⁵

83. The submissions just quoted differed in emphasis from those of other members of the medical profession and such bodies as the AMA and the Royal College of Obstetricians and Gynaecologists (Australian Council).

84. A number of studies have been conducted into the morbidity of the pill but it is virtually impossible to set up the necessary controls or to conduct the study over a long enough period of time to prove a connection between the pill and various diseases. For this reason, it is difficult to know whether the diseases of pill takers would have occurred in any case, not connected with the pill.³⁶

85. A number of major studies have noted differences in the incidence of disease between study and control groups in prospective surveys, but explaining these differences has been difficult.

86. For example, a prospective study of 23 000 pill takers and a similar number of controls in the United Kingdom, in 1974, produced the following conclusions:

. . . it seems that the estimated risk at the present time of using the pill is one that a properly informed woman should be happy to take . . . perhaps the most dramatic observation is the very small proportion of diseases which are materially affected by oral contraceptive usage.

32. Evidence, pp. 477-9, Dr Herbert Rattner.

33. Submissions 10, Mrs Anne Hapke; 29, Dr Jules Black; 211, Knights of the Southern Cross; 454, Ms G. Pack; 527, L. G. & P. M. Colman; 535, Miss Yvonne Foster; 619, Abortion Law Repeal Assoc. (NSW); 1073, National Right to Life Association; 1146, Dr J. Billings.

34. Submission 1146, Dr J. Billings.

35. Submission 211, Knights of the Southern Cross.

36. J. W. Goldzieher & T. S. Dozier, 'Oral contraceptives and thromboembolism: a reassessment', *Am.J.Obstet. & Gynaecol.* 128, 8 (1975), pp. 878-913.

Not a single previously unsuspected important adverse effect of the pill has been revealed by the study so far, and several suspected risks have been shown to be small, or non-existent. The risk of serious illness is very small.

87. Pill users report an average of six episodes of illness every 3 years while non-users report five. But because women on the pill tend to report their health problems more often:

. . . the evidence suggests that oral contraceptive users suffer in total no more episodes of illness than non-users, and they may actually have less.

The synopsis to the report noted, however, that:

Pill takers tend to differ from other women. They are generally younger and have more children (they have their families before going on to the pill). There are more smokers among them and they smoke more heavily (an average of 6.45 cigarettes per day compared with 5.28 among the controls.) They are also less likely to have had a previous serious illness because when selecting a patient for the pill a doctor would take into account previous medical history.

Because patients taking the pill may be concerned that they are taking a drug the total effects of which are not fully understood, and because they are likely to see their doctor more often, if only to pick up a repeat prescription, there is often considerable over-reporting of illness by takers compared with controls. Overall pill takers seem to report similar conditions some 19 per cent more than non-takers. In some conditions with ill-defined symptoms, such as migraine, headache or loss of libido, this bias may be much higher.

88. In many cases the researchers had difficulty in interpreting their results:

. . . the evidence concerning a possible carcinogenic effect of the pill is so far reassuring. It must be emphasised, however, that observations are required on a large number of women who have used the pill for a minimum of 10 years before any confident conclusions can be drawn.

Reported incidents of NEUROTIC DEPRESSION are 30 per cent *higher* among takers but 'substantial bias is likely to be present and the real increased risk of depression may be much smaller'. The maximum risk of such depression could be 22 per 1000 users a year.

Pill takers complain four times more *often* than non-users of DIMINISHED LIBIDO (sex drive). But the report says: 'Clearly it is much easier for a woman to talk about her sexual feelings when she is discussing contraception with her doctor than at other times, so it is likely that there is considerable bias.' It adds: 'Oral contraceptive users certainly complain of loss of libido more than non-users, but they have many reasons and opportunities to do so which are unconnected with the pharmacological action of the pill.'

MIGRAINE and HEADACHE present great problems in interpretation, because there are generally wide variations in reporting the conditions and pill users are likely to complain more often to their doctor. Almost *twice as many* takers as controls reported migraine and more than *three times as many*, headaches. On migraine, the report concludes: 'Though an adverse effect . . . cannot be excluded any such effect is likely to be small.' On headache, it says: 'In spite of the threefold difference in reporting rates, there is no reliable evidence here that headache is a pharmacological side effect of the pill.'

The total number of women in the survey suffering from CORONARY ARTERY DISEASE (including HEART ATTACKS) is so small—only 41 cases in both takers and controls—that no conclusions can be drawn about the pill's potential effects, although there is a suspicion that there might be a link.

There is a statistically significant *increase* in reports of CEREBROVASCULAR ACCIDENTS including minor episodes as well as more serious 'strokes', but again the total number of cases—43 in all—is too small to justify an estimation of the risk.³⁷

37. Royal College of General Practitioners, *Oral contraceptives and health: an interim report from the oral contraception study of the Royal College of General Practitioners* (Pitman, Medical, NY, 1974), press release and synopsis.

89. The IPPF *Medical Bulletin* reports the result of a study which confirms the associations found by the Royal College of General Practitioners in the UK:

Women who had used oral contraceptives at the start of the study experienced a deficiency of hospital referrals for cancer, benign lesions of the breast, menstrual disorders other than amenorrhoea, duodenal ulcer, and retention cysts of the ovary; and an excess of referrals for cerebrovascular disease, cervical erosion, skin disorders, self-poisoning, migraine, venous thrombosis and embolism, hay fever, gall bladder disease, amenorrhoea, and sterility.

The report concludes however:

The available evidence does not yet allow a final balance to be struck between the benefits and risks associated with the new methods of contraception that have become widely used during the last two decades.³⁸

The task of delineating the morbidity and mortality that can be directly attributed to the pill remains to be completed.³⁹

90. The side effects of the IUD can include heavy periods and cramping and pelvic infection. Perforation of the uterus is rare and unlikely if the IUD is fitted by an experienced person.

91. The morbidity of the IUD is reported in a number of studies. The Vessey study, reported by the IPPF *Medical Bulletin*, finds that women in the study who used the IUD experienced more referrals to hospital for anaemia, varicose veins and pelvic inflammatory disease than did the control group.⁴⁰ Vessey et al. have reported elsewhere on the increased incidence of ectopic pregnancy in women wearing IUDs.⁴¹ Westrom et al. also report an increased incidence of pelvic inflammatory disease among women using the IUD in Sweden.⁴² In each case the increased risk was significant in statistical terms though small.

92. No serious morbidity is noted for the condom and diaphragm. Indeed, considerations of both mortality and morbidity place these methods among the safest effective methods. Less incidence of carcinoma of the cervix is reported by some.⁴³ Both methods may also protect women from cervical cancer and the condom protects both sexes from venereal disease. Contraceptive services and sex education services would do well to point out the advantages of these methods, particularly to the young female whose physical immaturity may indicate that the pill should not be prescribed.

93. Morbidity of vasectomy and female sterilisation operations has been little studied and, while there are few suggestions of serious morbidity associated with the former, some disquieting reports suggest that closer study should be made of the consequences of tubal ligation procedures.⁴⁴

38. IPPF, *Medical Bulletin* 10, 5 (1976), p. 3; reference is to M. Vessey, R. Doll, R. Peto, B. Johnson & P. Wiggins, 'A long-term follow-up study of women using different methods of contraception—an interim report', *J. Biosocial Science* 8 (1976), pp. 371-424.

39. e.g. see also J. I. Mann, M. P. Vessey, M. Thorogood & R. Doll, 'Myocardial infarction in young women with special reference to oral contraceptive practice', *BMJ* 2, 241 (1975), as reported in *International Family Planning Digest* 1, 3 (1975).

40. IPPF, *Medical Bulletin* 10, 5 (1976), p. 3.

41. M. P. Vessey et al., 'Outcome of pregnancy in women using an intra-uterine device', *Lancet*, March 1974.

42. L. Westrom, L. P. Dengtsson & P. Mardh, 'The risk of pelvic inflammatory disease in women using intra-uterine contraceptive devices as compared to non-users', *Lancet*, 31 July 1973, pp. 221-4.

43. Vessey et al., *J. Biosocial Science* 8 (1976).

44. C. A. Ballard, 'Abortion and sterilisation by vaginal hysterectomy', *Am.J.Obstet. & Gynaec.* 118, 7 (1974), p. 895.

Conclusions

94. In the present state of knowledge, the following conclusions may be drawn:

- (a) Although the side effects of the pill are frequently observed, many abate with time or may be removed with change in prescription. It has yet to be shown that the changes in metabolism associated with the pill constitute disease processes.
- (b) Serious disease consequences of the pill have yet to be fully demonstrated. Some serious complications do appear to occur although incidence surveys suggest that with certain exceptions the risk is small. High risk categories include women over 40, smokers, and women with pre-existing conditions such as diabetes, hypertension or cardiovascular disease.
- (c) Clinical experience of doctors specialising in contraceptive advice suggests a definite increase in the incidence of headaches and migraines, depression and loss of libido for some proportion of pill takers. These conditions respond positively to either a change in prescription or change in method of contraception. Doctors and other practitioners supervising the care of women taking the pill should treat complaints of disorders such as headache, loss of libido and depression seriously. It is too easy to dismiss any such complaint as imaginary or the symptom of another problem she may have. Persistence of these complaints warrants discontinuation of the pill and substitution of another method.
- (d) Although side effects of the IUD are observable, serious disease consequences have not yet been fully established for the IUD or for female sterilisation.
- (e) The prescribing routine for either the pill or the IUD should include a description of the usual benign side effects which may result and of the more serious side effects which should be reported immediately. Similarly, the risks associated with tubal ligation should be listed prior to operation.

95. On the evidence available we consider the oral contraceptive to be an effective method of contraception which has not been conclusively proved to constitute a serious health risk to women. Women in certain 'at risk' categories should be advised of the additional risk they may incur and about alternative methods of contraception. Complaints of disorders accompanying the use of oral contraceptives should be taken seriously and may warrant substitution of another method.

Morbidity and other risks of pregnancy

96. In advising women on methods of contraception, the doctor or practitioner should not exclude the risk of pregnancy from a description of each method, pointing out that pregnancy carries health, social and emotional risks.⁴⁵

97. Professor R. Shearman told us in evidence:

This is my own personal view and the view of the Council [Australian Council of the Royal College of Obstetricians and Gynaecologists] as well, that the risks of oral contraception which are well documented . . . are of fairly low frequency but fairly high magnitude when they happen, but they are not comparable with the risks of unwanted pregnancy . . . There are dangers, but there are more dangers in unwanted pregnancies, or even wanted ones.⁴⁶

45. Population Information Program, George Washington University, 'Effects of childbearing on maternal health', *Population Reports*, Series J, 8 (1975), p. 126.

46. Evidence, p. 3085, Professor Rodney Shearman.

98. The main risks in pregnancy are from haemorrhage, hypertension and sepsis, but there are multiple conditions and disease processes which can occur during pregnancy which increase the risks of these hazards.

99. Some aspects of maternal morbidity are under-researched, and often unacknowledged. Since most women in Australia become mothers this is a matter for regret.

100. Data from the South Australian Obstetric Audit indicated that 10.7 per cent of mothers sampled (92.5 per cent of all private deliveries in a 6-month period in South Australia) suffered toxæmia during pregnancy.⁴⁷ Dr M. W. Dunstone, who undertook this Audit for the Royal Australian College of General Practitioners, wrote to us:

I would estimate that about 30 per cent of women would have one or more major items of morbidity per confinement.

101. Morbidity affecting such things as sexual function is seldom referred to in journals or textbooks. More information is available on the social and psychological consequences of pregnancy and childbirth. Depression, post-partum psychosis, anxiety, social rejection or isolation, financial insecurity or impoverishment are serious consequences with long-term implications that may occur.

Benefits from contraception

102. Submissions and evidence to the Commission alluded to the dangers of the pill, IUD and female sterilisation; little mention was made of the benefits that these methods of contraception may bring to the health of individual women.

103. The interim report of the Royal College of General Practitioners in the UK lists the following possible beneficial associations of the pill: the lessening or cure of menstrual disorders, iron deficiency anaemia, pre-menstrual syndrome, benign breast neoplasia, wax in the ear, ovarian cyst, acne and sebaceous cyst.⁴⁸

104. Some women experience side effects from the pill; others feel better when they are taking the pill than when they are not. Sometimes the pill alleviates hormone deficiencies and sometimes it relieves pre-menstrual symptoms, dysmenorrhoea (painful periods) or menorrhagia (excessive bleeding).

105. Many women experience psychological benefits from the use of effective methods of contraception due to the release from the fear of pregnancy. Women responding to the Commission's 'unwanted pregnancy phone-in' were asked how they felt about their present method of contraception. Some replies were:

A great burden has been lifted from my mind [vasectomy].

I feel really confident of not falling pregnant [pill].

It gives me complete freedom, it's a great invention—better than men on the moon [pill].

106. One submission made this comment:

Possibly the current practice of contraception will in the long run improve the quality of motherhood, because only those women who really desire children will have them.⁴⁹

Contraceptive use

Introduction

107. Although effective methods of contraception exist, many unwanted pregnancies still occur. We estimate in chapter 3 (Unwanted pregnancies) that there may be as many as 100 000 each year in Australia of which more than 60 000 end in abortion.

47. Royal Australian College of General Practitioners, South Australian obstetric audit (unpublished).

48. RCGP, *Oral contraceptives and health*, interim report, 1974.

49. Submission 973, League of St Gerard Majella, Deniliquin.

This is a problem of considerable size. We therefore ask what can be done to ensure more effective contraceptive action by those who do not want to become pregnant. We consider the social and personal factors which affect contraceptive use.

108. The problem should be seen in proportion. There are many couples in Australia who are able to have the number of children they want, and to prevent further pregnancies occurring when their family size is completed.⁵⁰ Others are unable to limit their families or to avoid unwanted pregnancies. If some of the reasons for this could be established, programs could be devised and implemented to enable people at risk to take more effective contraceptive action and to plan their family size.

Women at risk

109. The main problem in any such study is to identify categories of women who do not want to become pregnant and to link those women with a reason or reasons for ineffective contraception. It is not possible to categorise all women at any one time into those who are willing to become pregnant and those who are not. There is another category of women who are ambivalent about pregnancy or who are undecided, and it is this group who are often inconsistent in their use of contraceptives or who fail to take any contraceptive action. It is too easy for the investigator to assume that births are either planned or unplanned. For many people children 'just come' and are wanted even if they strain their parents' ability to cope and increase their vulnerability to poverty.⁵¹ If there is a social problem it involves more than just the prevention of births.

110. Another problem arises from the fact that most survey material is based on interviews with married women and does not always take into account the male attitude or his responsibility for contraception, nor the position of single women who are a group at special risk.

111. For similar reasons it cannot be assumed that women who use no contraceptive method or who use one of the less effective methods are necessarily an at-risk group. The method chosen may depend on how willing the woman is to accept a pregnancy. For example, a less effective method, or no method, may be chosen by a married woman if she has not attained the desired family size.

112. It is not easy to identify pregnancies that are truly unwanted. Some women request termination of pregnancy and there are some data about their characteristics and pattern of contraceptive use. Another group give birth to ex-nuptial children, some of whom are adopted. These are mainly young single women, and it can be assumed that a proportion of their pregnancies are unwanted; others may be wanted children born within a stable relationship.

113. There are women who may have preferred to avoid a pregnancy but do not consider it as unwanted when it occurs; the child is accepted and abortion or adoption is not considered. Nevertheless these women may be having more children than they can afford or cope with, because they are unable to practise effective contraception or do not know enough about it.

114. The categories at risk include the women who seek termination of pregnancy, many of those who surrender children for adoption, some who have ex-nuptial children and those who have more children than they really want or families too large to cope with.

50. Helen Ware, 'The limits of acceptable family size: evidence from Melbourne, Australia', *Journal of Biosocial Science* 5 (1973), pp. 309–28; C. M. Young, 'Numbers of children planned, expected and preferred by women in Melbourne', *Journal of Biosocial Science* 6 (1974), pp. 295–304; A. H. Pollard, Farhat Yusuf & G. N. Pollard, 'Survey of family formation in Australia—2: The ideal family formation', Working Paper no. 14 (Macquarie Uni., Sydney, 1974), p. 7.

51. *Social/medical aspects of poverty in Australia*, p. 136.

115. Although women requesting termination of pregnancy are only a section of all women having unwanted pregnancies, they are an important group about whom data are available. Some of the characteristics of women requesting termination are set out in chapter 4 (section on incidence of abortion.) A social worker, June Bell, identified the following groups:

- (a) The very young girl (aged 13 to 16) who is still at school.
- (b) The girl who may have left school and has started work, or who may have continued at school and plans to go on to university.
- (c) The older girl who may have one child and is still unmarried.
- (d) The young married woman who may have very young children and is not prepared for any more now.
- (e) The older married woman who has had her family and is shocked by a sudden pregnancy.
- (f) The young married woman who, in fact, does not want any children and who often requests permanent contraception—even in her mid 20s.⁵²

Abortion patient surveys analysed also show that these women are younger than the average (especially in the 15–25-year-old group) and more likely to be unmarried than married and are likely to have no children if single or more than two if married.

116. The Poverty Commission considered that the groups for whom present contraceptive services are inadequate include 'parents of large families, young unmarried women, Aborigines and some migrant groups'.⁵³ They noted that poor people have been less successful in controlling their fertility and that their families are often larger than average. Aborigines too have larger families on average.

117. A Preterm survey suggested that there was an over-representation of migrant women due to the clinic's inner city location; cultural acceptance of abortion (especially among Yugoslavs); economic insecurity; inefficient contraception; and the dearth of interpreters.

118. Statistics for ex-nuptial births show that about 40 per cent are to women under 20. Evidence to the Commission showed that the proportion of 15–17-year-olds becoming pregnant ex-nuptially is increasing.⁵⁴ Ex-nuptial births show a slight decline since 1972 though they still account for over 9 per cent of all births.

119. The circumstances of ineffective contraception or no contraception are varied. Some fail to take up any method on becoming sexually active; some use less effective methods or choose effective methods but use them ineffectively; and some discontinue a method without replacing it with another. Information about women requesting abortion shows that while the majority were using no method of contraception at the time of conception, others were or had been using contraception.

The reasons are as varied as the circumstances:

- (a) the young single girl may be affected by problems of access to services or by medical attitudes;
- (b) parents of large families may be affected by poverty, by religious beliefs or ignorance;
- (c) migrants may be affected by the language barrier or by social customs and traditional contraceptive practices.

52. Exhibit 94.

53. *Social/medical aspects of poverty in Australia*, p. 147.

54. Evidence, pp. 1417–8, Robin Harnett.

All women may at some time be affected by ambivalence about pregnancy. Other reasons include ignorance, risk taking, apathy and lack of services. The reasons for ineffective contraception are quite distinct from the reasons why a pregnancy is not wanted.

Knowledge and use of contraception

120. In Australia there is a relatively high awareness of contraceptives although there are some groups who have insufficient knowledge, particularly the young and single and those for whom there is a cultural barrier.

121. The Family Formation Project survey of married women in Melbourne, in 1971, found the distribution of knowledge of the various methods of contraception by the married women interviewed as shown in table IV.7. Although nearly all respondents had heard of the rhythm method and withdrawal, two of the least reliable methods of contraception, approximately 30 per cent had never heard of the IUD, of the diaphragm or of spermicides; 20 per cent had not heard of condoms.⁵⁵

Table IV.7 Knowledge of specific methods of family planning (respondents under 60 years of age)

| Method | Knowledge (percentage) | | |
|--------------------------------------|------------------------|---------------------|-------------------|
| | Have heard of or used | Have never heard of | Refused to answer |
| Pill | 95 | 4 | 1 |
| Withdrawal | 91 | 8 | 1 |
| Rhythm | 89 | 10 | 1 |
| Abstinence from sexual relations | 84 | 15 | 1 |
| Condom | 79 | 20 | 1 |
| Douching | 72 | 27 | 1 |
| Spermicides (named separately) | 70 | 29 | 1 |
| Grafenberg or similar rings | 69 | 30 | 1 |
| IUD | 68 | 31 | 1 |
| Diaphragm | 67 | 32 | 1 |
| Quinine pessary | 37 | 62 | 1 |
| Sponge | 35 | 64 | 1 |
| Spray foams, pressure pack and so on | 31 | 68 | 1 |

Source: Caldwell, Young, Ware, Lavis & Davis, 'Australia: knowledge, attitudes and practice of family planning in Melbourne, 1971', *Studies in Family Planning* 4, 3 (1973), p. 52.

Knowledge of methods usually rises with the level of education.

122. Other studies suggest a lower level of knowledge among young people. A study of 200 mothers, of all ages, delivered at Queen Victoria Hospital in 1969 found that 71 per cent admitted to pre-marital intercourse; only two-thirds had knowledge of birth control at that time and less than half had used any form of contraceptive. The methods best known were the pill, rhythm, loop or ring and condom.⁵⁶ This study was retrospective; similar comments were made by women attending the Fertility Control Clinic in Melbourne.

Some of the questions asked of women attending the Fertility Control Clinic concerned aspects of their sexual knowledge and activity. The most striking conclusion to come out of these questions is the widespread ignorance of contraception especially, although not exclusively, among the young.⁵⁷

55. Caldwell et al., *Studies in Family Planning* 4, 3 (1973).

56. C. Wood, N. de Mestre, R. Mackenzie, M. Barson & E. Lewis, 'Birth control in a lower social group in Melbourne', *Medical Journal of Australia*, 27 March 1971, pp. 691-6.

57. J. Wainer, 'Abortion clinic', *La Trobe Sociology Papers*, Paper no. 8 (1975).

Overseas studies confirm that, particularly among the young, there are misconceptions about the risks of pregnancy and of methods of contraception.⁵⁸

123. Use of contraception does not follow the same pattern as knowledge of a method. In the Melbourne survey of 1971, 54 per cent of the sample had never used the pill, though 95 per cent had heard of it. This survey found that only 13 per cent of the married women respondents had never practised any form of family planning. Fewer than 10 per cent of the younger women in the sample had never used contraception.

Table IV.8 Main method of family planning employed 1970–71 (percentage of all users, respondents under 60 years of age)

| Method | Whole sample | Native-born |
|---|--------------|-------------|
| Abstinence | 1 | 1 |
| Rhythm | 14 | 14 |
| Withdrawal | 19 | 5 |
| Condom | 9 | 9 |
| Jellies and chemicals | 2 | 4 |
| Douching | 1 | — |
| Diaphragm | 5 | 6 |
| Grafenberg ring | 2 | 3 |
| IUD | 8 | 10 |
| Pill | 38 | 47 |
| Other and not specified | 1 | 1 |
| | 100 | 100 |
| Number total users | 1737 | 1051 |
| Users as a percentage of all fecund married women | 92 | |
| Users as a percentage of all married women | 66 | |

Source: Caldwell & Ware, 'Evolution of family planning in Australia', *Population Studies* XXVII, 1 (1973), p. 25.

The authors comment that the relatively high level of use of withdrawal is due to the large proportion of southern European immigrants among whom it is a common method. Catholics have a higher rate of use of abstinence and of rhythm. These surveys relate only to married women. There is no comparable information about the knowledge of and level of use of contraceptive methods by single women in Australia.

Attitudes and other factors affecting contraceptive use

124. We are particularly concerned to establish which groups in the community use no contraception, or use ineffective methods, and to determine whether there are reasons for this unassociated with the desire to become pregnant.

125. Contraceptive use is affected by a person's religion, education and birthplace. Some people hold beliefs which preclude contraception or the use of the most effective methods. The Australian Family Formation Project survey of married women in Melbourne, in 1971, found that the lowest rate of approval of contraception was

58. M. Zelnick & J. F. Kantner, 'Sexuality, contraception and pregnancy among young unwed females in the United States', in C. F. Westoff & R. Parke Jr (eds), *Demographic and social aspects of population growth*, Commission on Population Growth and the American Future, 1 (1972), pp. 361–2; M. L. Finkel & D. J. Finkel, 'Sexual and contraceptive knowledge, attitudes and behaviour of male adolescents', *Family Planning Perspectives* 7, 6 (1975), p. 257; Schofield, p. 87.

among southern Europeans (59 per cent), Catholics (69 per cent) and those with no more than elementary education (74 per cent). Where these three categories coincide the rate of approval is only 36 per cent. In many cases disapproval was restricted to methods which were perceived to be unnatural. The highest rate of approval was among tertiary educated Australian non-Catholics (98 per cent) and the rate for the whole sample was 86 per cent. Catholics' use of rhythm and abstinence is well above average and their use of condoms, spermicides and diaphragms is well below average. Their use of withdrawal, the pill and the IUD is also below average, though less markedly so.

126. Cultural values account for some differences in contraceptive use. For example, in some cultures fertility is controlled by the male by the use of coitus interruptus (withdrawal). Strong beliefs that this is how fertility should be controlled, associated with cultural restraints on the autonomy of women, often preclude other methods of contraception. Data from the Melbourne Family Formation Project demonstrate this clearly. Withdrawal was used by 74 per cent of Greek-born contraceptors, 73 per cent of Yugoslav-born and 62 per cent of Italian-born, compared with 5 per cent of Australian-born.⁵⁹ The Poverty Commission were disturbed that migrant women were more likely to be using less reliable methods particularly in view of the high incidence of migrants in poverty.⁶⁰

127. The level of education is a significant factor. The Melbourne survey found that withdrawal is mainly used by the less well educated, irrespective of birthplace. The usage rate of the pill and the condom increase with the level of education.⁶¹ Caldwell and Ware noted:

To take the pill as an example, within the first 3 years of its introduction, 23 per cent of the wives with tertiary education had adopted this new method compared with 3, 12 and 18 per cent respectively of those with elementary, lower secondary and upper secondary education as their highest achieved levels (taking educational approximations of the length of full-time education). Over the decade, the educational differential in pill use has declined, especially amongst the Australian-born. However, it should be noted that by 1970-71 a new innovational differential had appeared: the most highly educated women had already begun to move away from the pill whilst levels of usage were reaching a plateau or still rising in the other educational groups.⁶²

For practically every group the percentage of married women who have ever used the pill increases with the level of education. The lowest rate of use of the pill (at any time) was among southern Europeans, particularly Roman Catholics and Orthodox, with no more than primary education (14 per cent of the total sample). The authors comment that:

. . . whilst the use of artificial methods of contraception rises with education amongst the non-Catholic-born outside southern Europe, it declines with education amongst the Catholic-born there.⁶³

128. Research studies based on the Melbourne Family Formation Project survey also show that other factors affect the patterns of effective contraceptive use. These include age, length of marriage and number of children. Younger women were more likely to be using the pill than older women, though among the latter it was still the most commonly used method. Women with fewer children appear to be using more effective methods (pill, IUD, condom and diaphragm) than those with more children,

59. Caldwell & Ware, *Population Studies* XXVII, 1 (1973).

60. *Social/medical aspects of poverty in Australia*, pp. 152-4.

61. Caldwell & Ware, p. 26.

62. *ibid.*, p. 7.

63. *ibid.*, pp. 27-8.

Table IV.9 Percentage of Australian-born women who have ever used certain methods of contraception by religion

| | Catholic | Ex-Catholic | Anglican | Protestant | Other | Sects | None | Total |
|--|----------|-------------|----------|------------|-------|-------|--------|-------|
| Catholic usage above average | | | | | | | | |
| Rhythm | 50 | 31 | 18 | 20 | 25 | 18 | 26 | |
| Abstinence | 20 | 13 | 14 | 13 | 8 | 12 | 15 | |
| Catholic usage half average to average | | | | | | | | |
| Withdrawal | 20 | 28 | 25 | 24 | 22 | 26 | 24 | |
| Pill | 43 | 80 | 57 | 57 | 50 | 73 | 56 | |
| IUD | 7 | 10 | 10 | 10 | 11 | 14 | 10 | |
| Grafenberg ring | 6 | 10 | 8 | 8 | 14 | 16 | 10 | |
| Douching | 2* | 4 | 5 | 2 | 8 | 6 | 4 | |
| Catholic usage less than half average | | | | | | | | |
| Condoms | 12 | 34 | 30 | 34 | 33 | 28 | 27 | |
| Spermicides | 5 | 4 | 16 | 20 | 14 | 20 | 15 | |
| Diaphragm | 4 | 17 | 23 | 22 | 33 | 22 | 19 | |
| Number | 362 | 29 | 533 | 455 | 36 | 199 | 2 652† | |

* Exact percentages show Catholic usage of douching to be more than half the average for all religions.

† Includes women from minor religious groups not tabulated separately.

Source: Caldwell and Ware, *Population Studies* XXVII, 1 (1973).

especially those with five or more children. Among the latter group there is a higher proportion of women using withdrawal and rhythm than all other methods.⁶⁴ The table on which this information is based places women who at the time of the interview stated that they wished to become pregnant in a separate category.

Conclusion

129. It seems fair to conclude on the basis of this information that, so far as married women are concerned, migrants, the less well educated and Roman Catholics seem to incur greater risk of having a pregnancy they would rather have avoided because their level of contraceptive use is lower and their chosen method likely to be less effective. It should be noted that migrants, particularly the southern Europeans, are mostly in the category of having no more than primary school education.

130. No similar information is available about single women. We believe that further research is needed to bring up to date the information gained from the Melbourne Family Formation Project and to include a sample of single women, especially young women who appear to be a high risk group and who have either insufficient knowledge or motivation to use contraception effectively. We welcome a recent initiative for further research on the part of the Department of Health and express the hope that it may prove possible to survey some men.

Attitudes towards contraceptive methods

131. Quite apart from the demographic characteristics which affect the pattern of contraceptive use, there are less easily definable attitudes to contraceptive methods. For example, some people hold a 'general notion of non-interference with the body as a whole'.⁶⁵ Such values place contraception, particularly methods which involve chemicals or devices, in the categories of 'unnatural' and 'unhealthy'. Some people equate femininity with breeding; they consider that children must follow on from marriage and that sexual intercourse is for reproduction. Such views preclude the use of contraception, particularly in early marriage, and sometimes also pre-maritally. Sandberg and Jacobs comment on:

. . . the situation in which the woman offers a demonstration of her love by the gift of pregnancy, a frequent and highly acceptable aspect of married love but a complicating element in unmarried love.⁶⁶

Others fear contraception, or some methods of contraception. In two separate small surveys carried out by Professor Wood, in Melbourne, it was found that contraceptives were less acceptable than had been believed.⁶⁷ The study of a lower socio-economic group of women found a high incidence of fear and adverse reactions to contraceptives. The later study also found neutral and negative attitudes to contraceptive methods. The pill was most favoured and rhythm least favoured on various scales. Professor Wood concluded in the second study that either methods have to be changed or attitudes altered if contraceptives are to be used successfully and that the emotional attitude of patients should be considered in counselling.

132. An English study found significant numbers of women who regarded certain methods of contraception as very unsatisfactory or rather unsatisfactory: safe period,

64. Lavis, pp. 94-5.

65. H. Ware, *Methodological issues: investigation of body notions, communication patterns and ideas about tampering with nature* (ANU, Canberra).

66. E. C. Sandberg & I. R. Jacobs, 'Psychology of the misuse and rejection of contraception', *American Journal of Obstetrics and Gynaecology* 110, 2 (1971).

67. Wood et al., 'Birth control in a lower social group in Melbourne', *MJA*, 27 March 1971, pp. 691-6; C. Wood, 'A study of attitudes to contraceptives in a middle class group of women', *Medical Journal of Australia* 1 (1974), pp. 659-60.

72 per cent; diaphragm, 38 per cent; sheath, 35 per cent; IUD, 17 per cent; pill, 15 per cent. The author concluded that availability was a barrier to the wider use of the pill and the IUD.⁶⁸

Problems in the use of contraceptives

Inability to find a method to suit

133. A growing problem is that of women who cannot find a method of contraception to suit them. The problem frequently arises when neither the pill nor the IUD can either be tolerated or prescribed for medical reasons. The side effects of the pill cannot always be overcome even through careful management. Some women are reluctant to use chemical methods. Short of sterilisation, this situation leaves only the less reliable methods of contraception, with their disadvantages. Consistent use may be hindered by dislike of these methods. Women need good advice to help them to choose a method which suits them and which they can use effectively. A less reliable method if used properly may be more effective than a better method poorly used. Contraceptive technology and the acceptability of contraceptives should in our view be the subject of much more research.

Difficulties in use and method failure

134. Some contraceptives are difficult for some people to use. Understanding of the mode of action and of the effects and side effects is necessary. The oral contraceptive, for example, is not effective for at least the first 14 days of use, and an additional method has to be used during this time. There are varying rules about what to do if a pill is forgotten. The woman on the pill must also be aware that vomiting or diarrhoea can prevent proper absorption of the hormones and make the pill ineffective. She should know and apply the rules for missed pills and, if necessary, use another method of contraception.

135. Many of the side effects of the pill are mild or develop slowly, for example nausea, depression and loss of libido. It is hard to tell if these are caused by the pill and sometimes this can be established only by discontinuation. It requires perseverance to stick to the pill during 2 or 3 months of nausea or headaches on the expectation that these symptoms will ease. Women are also exposed to sensational reports of the dangers of the pill⁶⁹, many of which are unreliable or over-emphasised.⁷⁰ Many women discontinue the pill because they do not know enough about its use and effects.⁷¹

136. There are comparable problems with other methods; for example, women using the IUD need to be advised to report abdominal pain or vaginal discharge.

137. Accurate information and instruction for both partners are also needed for the periodic abstinence methods. Properly used, these methods require, among other things, conscientious self-observation, knowledge of the female cycle and the things which may disrupt it, acquaintance with the range of vaginal disorders likely to disrupt mucus symptoms and the emotional and physical factors which alter body temperature cycles. The reasons for discontinuing this method may include difficulty in identifying and interpreting symptoms, and difficulties in coping with the method in times of stress.

68. Ann Cartwright, *Parents and family planning services* (Routledge & Kegan, London, 1970), p. 39.

69. e.g. 'The pill: the only pleasant suicide', *Australian International News Review*, 7 December 1965.

70. G. Bertuch & J. Leeton, 'The effect of publicity on oral contraceptive practice', *MJA* 2 (1971), p. 1067.

71. Emmi Snyder & Susan Wall, *Abortion in Sydney: a perspective on change* (Preterm Foundation, Sydney, 1976), p. 23.

138. The proper use of the diaphragm and condom also require adequate information about the way the method works and instructions for correct usage.

139. Difficulties in use can contribute to the failure of a method. A report on 1007 women requesting abortions at Preterm in 1974 reveals that 379 (37.6 per cent) had been using a method at the time of conception including the following:

| | % |
|--------------------------|------|
| Oral contraceptives | 4.4 |
| Condom alone | 4.4 |
| Coitus interruptus alone | 11.0 |
| Spermicides alone | 4.5 |
| Rhythm alone | 4.5 |
| IUD | 2.7 |
| Diaphragm alone | 0.7 |
| Other | 5.4 |

This may be explained by ineffective use or by method failure. Of those not using contraceptives, 2.7 per cent of the total had been advised by the doctor to stop the pill with no alternative suggested method and 12.5 per cent of the total had stopped the pill of their own accord.⁷²

140. Other surveys have produced similar results. The survey of 660 women attending the Children by Choice counselling service in Brisbane reported that 33 per cent had been using contraception at the time of conception including the following:

| | % |
|--------------|------|
| Rhythm | 12.0 |
| Pill | 6.0 |
| Foam/tablets | 4.3 |
| Condom | 3.0 |
| IUD | 2.0 |

Of the 67 per cent not using contraceptives, 2 per cent of the total had been advised by the doctor to stop taking the pill and 11 per cent had stopped taking the pill of their own accord.⁷³ A survey of 338 women students in Melbourne reported that one of the rhythm methods is commonly involved in unplanned conceptions among students.⁷⁴

141. The survey of 1736 women attending the Fertility Control Clinic in Melbourne in 1973–74 showed that 26 per cent of teenagers and 40 per cent of women in their 40s were using some form of contraception when they became pregnant, mainly rhythm or the condom.⁷⁵

142. A survey of abortion patients carried out for the Lane Committee in England showed that 23 per cent had been on the pill before becoming pregnant; 9 per cent forgot to take it, 13 per cent stopped because of symptoms and 1 per cent were taken off by the doctor.⁷⁶

72. *ibid.*, p. 21.

73. S. Rigg, *Clients of Children by Choice*, Brisbane, Commission research report, no. 4, 1976.

74. Submission 556, Cole & Beighton.

75. Submission 73, J. Wainer.

76. A. Cartwright & S. Lucas, 'Survey of abortion patients', *Report of the Committee on the Working of the Abortion Act* (hereafter referred to as the Lane report), vol. III, p. 62.

143. In some of the cases referred to the method of contraception was ineffective, i.e. it had a high failure rate even if properly used. In other cases it seems fair to assume that there was an incorrect use of the method. The reports suggest further elements of lack of adequate information and advice and unacceptable side effects, especially in regard to the pill. A survey of 209 women who had babies at the Queen Victoria Hospital in 1969 reported that, of those who had ceased using birth control, 23 per cent did so because of the side effects and 6 per cent because of difficulty in use of the method.⁷⁷

144. A more recent survey of 1000 women requesting abortion at Preterm in 1976 showed that 662 were women who had been using oral contraceptives at the time of conception or who had previously discontinued their use. Of these 662 women, 575 or 87 per cent had stopped taking the pill of their own accord; 374 or 65 per cent of these did so because they experienced side effects from the method; a further forty-five, 7 per cent, stopped because they were misinformed about the need to have a break from the pill; another five did not know they could use the pill while breast-feeding and four did not understand the importance of taking the pill for the full 21 days.

145. Of the remainder of women who were taking the pill, sixty had used the method incorrectly, including fifty-eight who had forgotten to take some pills during the month. Twelve were advised to discontinue the pill by their doctor in order 'to have a break'. These women were not experiencing side effects. Fifteen women experienced method failure, including seven who had suffered vomiting and diarrhoea during the month.

146. Only nine of the previous pill takers had thought that they wanted to become pregnant, and a further eight were 'aesthetically unhappy' about taking oral contraceptives. There is no information about the non-pill-takers.⁷⁸

147. In a submission to this Commission, Cole and Beighton reported six cases in a sample of female university students:

... in which the medical profession contributed to an unwanted conception by failing to discuss alternative methods with women who had to cease oral contraception on medical grounds.⁷⁹

It appears that the withholding of information about side effects and long-term consequences, and the refusal to acknowledge that side effects could be due to the contraceptive, are factors contributing to abandonment of the pill. Withholding of information may also give the impression that the side effects and long-term consequences are more serious than they really are.⁸⁰

148. The Commission recognises that it is time consuming for the doctor, nurse or counsellor to list all of the eventualities which may occur and the ways in which these should be handled. The FPA deals with telephone inquiries, but this is not necessarily known to the many women who receive their prescriptions from a GP. Printed sheets of information could help. These could be incorporated in packets of the pill, diaphragm and condom so that the user would have ready access to the information. Manufacturers have already moved in this direction and we commend this move. These instructions should be as full as possible and should be written in several languages.

77. Wood, de Mestre et al., pp. 691-6.

78. Preterm, Sydney, Series of 1000 patients requesting abortion in the period 1 July 1976-1 September 1976 (report in preparation).

79. Submission 556, Beighton & Cole.

80. Preterm survey (report in preparation).

Non-use of contraceptives

149. A few women become pregnant when using some form of contraceptive. However, most women who have unwanted pregnancies appear to have been using no contraception at the time of conception. Once again, our information is limited to women seeking abortion. A report on 1007 women requesting abortions at Preterm Clinic in Sydney in 1974 reveals that 171 (17 per cent) had never used a method of contraception and that 62 per cent had been using no method at the time of conception. A much higher proportion of married women (54.7 per cent) than single women (29.7 per cent) were using contraception at the time of conception.⁸¹

150. A survey of women attending the Fertility Control Clinic in Melbourne reported that 21 per cent had never used a method of contraception; at the time of conception 74 per cent of the teenagers and 40 per cent of the over-40s were using no method of contraception.⁸² A study of young people in London aged 15 to 19 found that although about 80 per cent of boys and girls claimed to have some knowledge of birth control, a quarter of the boys and more than half the girls with sexual experience never took precautions; others did so only occasionally.⁸³ These findings are significant, since most in this group could be presumed not to want a pregnancy.

151. The fact is, then, that many people fail to use contraception despite a wish not to become pregnant. The reasons are varied and range from ignorance and misinformation to risk taking, fatalism and lack of access to services. The difficulty of identifying any particular group is brought to light by the range of responses in the Melbourne survey of married women for the Australian Family Formation Project in 1971. Thirty-nine per cent of respondents stated they had become pregnant on at least one occasion because they 'took a chance sometimes'. Of these, 65.7 per cent didn't care very much if they did become pregnant; 19.6 per cent were in the category 'something stopped me from taking the precautions'; 3.4 per cent didn't know enough about why one became pregnant; 2.3 per cent used a method which they did not really think would work or knew to be chancy; 0.3 per cent thought they were sterile. Of the women who 'did not care very much', 86.7 per cent replied 'yes' to the question: 'Would you say that you were quite pleased that fate took a hand and made you pregnant without your having to make the decision yourself?'⁸⁴

152. The report also analysed the reasons given for the category 'something stopped me from taking the precautions' (see table IV.10).

153. It is particularly difficult to establish after the event the reason why no contraception was used in cases where pregnancy was not wanted. The form of the question and the person's rationalisation may cloud the issue. Married women may give a range of replies different from those of single women; women seeking abortions may give answers different from those of other women who consider that their pregnancy was not planned or wanted. Most of the surveys are confined to women and, although some referred to the role of their husband or partner, the views of men have not been directly surveyed.

81. Snyder & Wall, p. 23; see also Cartwright & Lucas, Lane report, vol. III; Beard et al., 'Kings termination study 2: contraception practice before and after outpatient termination of pregnancy', *British Medical Journal*, 9 March 1974, p. 420.

82. Submission 73, Jo Wainer.

83. Schofield, pp. 88-91.

84. Dept of Demography, Australian Family Formation Project, Melbourne survey, numerical and percentage distributions of responses (ANU, Canberra, 1972).

Table IV.10 Reasons why ‘something stopped me from taking the precautions’

| Reasons | % |
|---|------|
| 1. Orals—just cannot remember to take them | 6.8 |
| 2. Orals—ran out of supplies | 4.0 |
| 3. Other contraceptives—ran out of supplies | 6.0 |
| 4. Other contraceptives—decision to have sex too sudden to use them | 18.9 |
| 5. Other contraceptives—suddenly wanted to have sex without them; was breast-feeding, thought it was safe | 18.1 |
| 6. Other contraceptives—husband not in condition to take care | 12.4 |
| 7. Other contraceptives—unpleasant (or too cold) to take the trouble getting them | 3.2 |
| 8. Confusion between husband and wife—each thought the other was taking some precaution | 1.6 |
| 9. Don’t know (including some fed up with abstinence during unsafe period) | 28.9 |

Source: Australian Family Formation Project, Melbourne survey (Dept of Demography, ANU, Canberra).

Survey of reasons

154. In addition to the Melbourne Family Formation Project survey just referred to, we have looked at several other Australian and overseas surveys about failure to use contraception. Most, but not all, concerned women seeking abortion.

155. Contraceptive use was examined in a study of 209 women who had babies at the Queen Victoria Hospital, Melbourne, in the last 3 months of 1969.⁸⁵ The women were asked whether they had ever used birth control and, if not, their reasons for not doing so. In contrast to samples of abortion patients, a number of these women had planned their pregnancies. The data showing their reasons appear in table IV.11.

Table IV.11 Reasons for not using birth control

| Reasons | % | Percentage of those not wishing to become pregnant |
|---------------------------------------|----|--|
| Desire for larger family | 45 | .. |
| Insufficient knowledge | 30 | 55 |
| Religious objection | 10 | 18 |
| Fear of side effects of contraception | 8 | 14 |
| Husband objects | 5 | 9 |
| Disturbance of sex life | 1 | 2 |
| Difficulty in use of method | 1 | 2 |

Source: Wood, de Mestre et al., ‘Birth control in a lower social group in Melbourne’, *Medical Journal of Australia*, 27 March 1971, pp. 691–6.

156. The Fertility Control Clinic reported that in the case of young women the reasons include ignorance and misinformation, uncertainty on the morality of their sexual involvement, risk taking, fear of seeing a doctor and refusal by the doctor. Older women’s reasons were misinformation about fertility or the menopause, unexpected intercourse and refusal by their partner.⁸⁶

85. Wood, de Mestre et al., pp. 691–6.

86. Submission 73, Jo Wainer.

157. The Preterm survey of 1007 women seeking abortion in 1974 mentioned unplanned, unexpected intercourse as a reason for pregnancy.⁸⁷

158. Data were also gathered on contraceptive non-use during our 'unwanted pregnancy phone-in'. The most frequently mentioned reasons for not using contraception were 'I thought it wouldn't happen to me', ignorance and the unexpectedness of intercourse.

159. In a study of university women's contraceptive behaviour, Cole and Beighton note:

Many women in the sample believed that sexual intercourse should not play any part in the early stages of a relationship. They were therefore unprepared for the situation when it arose.⁸⁸

160. The Poverty Commission noted apathy, fatalism, lack of confidence in family planning and fear of its effects as factors impeding contraception.⁸⁹

161. Overseas studies also suggest that ignorance, misinformation, mismanagement and difficulties of access all contribute to poor contraceptive use. In the United States there have been two recent studies of women presenting for abortion.⁹⁰

Two studies—of 100 women who applied for repeat abortions in New York, and 642 women who obtained abortions in California—have found that the main reasons the women had unplanned pregnancies were misinformation about the menstrual cycle, about the risk of pregnancy and about proper use of their contraceptive, as well as fear of side effects and actual failure of the method. Very few of the women got pregnant because of objections to the use of contraceptives, an underlying desire to get pregnant, or reliance upon abortion as a primary means of birth control.⁹¹

162. Method failure, inconsistent or incorrect use accounted for up to two-thirds of the unplanned pregnancies; medical mismanagement and side effects were other factors. In the New York study, reasons for pregnancy included: thought it was the safe period; method failure; fear of contraceptive side effects; and risk taking.

163. Data from the 1970 National Fertility Survey in the United States show the reasons given by unmarried women for not using contraception (see table IV.12). The data indicate that, for this sample, ignorance of female fecundability was a major reason for not using contraception.

164. A survey for the Lane Committee of abortion patients in England not using or not always using a method of contraception reported the reasons shown in table IV.13.

Young people

165. The Fertility Control Clinic survey showed that of those women asking for abortions the younger ones were least likely to have used contraception. The Preterm study showed that married women (54.1 per cent) were more likely to have used contraception than the never married (29.7 per cent). The latter group were mainly under 21.⁹² Sexually active young people are at risk of unwanted pregnancies; they are also likely to be in situations where contraception is difficult, because of lack of experience, lack of access to services, or because the relationship is a casual one.

87. Snyder & Wall, p. 20.

88. Submission 556, Beighton & Cole.

89. *Social/medical aspects of poverty in Australia*.

90. I. J. Robins, 'Failures of contraceptive practice', *New York State Journal of Medicine* 73, 361 (1976); W. B. Miller, 'Psychological antecedents to conception among abortion seekers', *Western Journal of Medicine* 122, 12 (1975).

91. *Family Planning Perspectives* 8, 2 (1976), pp. 72–6.

92. Snyder & Wall, p. 17.

Table IV.12 Per cent unwed females giving specified reason for not using contraception

| Reason | Black | White |
|--|-------|-------|
| Trying to have baby; didn't mind if pregnant | 24.2 | 12.1 |
| Too young; infrequent sex; didn't think could get pregnant | 27.8 | 16.4 |
| Time of month when couldn't get pregnant | 21.4 | 42.5 |
| Hedonism—heedlessness ^(a) | 7.2 | 9.6 |
| Knowledge—logistic ^(b) | 12.7 | 14.2 |
| Partner objects; wrong to use | 3.0 | 4.5 |
| Other ^(c) | 3.8 | 0.7 |
| Total | 100.0 | 100.0 |

(a) 'No fun to use'; too 'inconvenient'; 'didn't want to use'; 'just didn't'.

(b) Didn't have contraception available; didn't know where to obtain; didn't know about contraception.

(c) 'Dangerous'; medical reason for believing to be infecund; 'too expensive'.

Source: M. Zelnick and J. F. Kantner, 'Sexuality, contraception and pregnancy among young unwed females in the US', in Westoff and Parke (eds) *Demographic and social aspects of population growth*, Commission on Population Growth and the American Future, vol. 1, p. 370.

Table IV.13 Reasons for not using or not always using a method of contraception

| Reason | % |
|--|----|
| Doctor took them off pill | 1 |
| Symptoms associated with pill | 13 |
| Forgot to take pill | 9 |
| Did not have sheaths available | 9 |
| Said he would withdraw and did not | 5 |
| Spontaneity, intercourse not expected | 17 |
| 'It wouldn't happen to me' | 18 |
| Other | 17 |
| Inadequate answer or no reason given | 24 |
| Number of women not using or not always using a method of contraception (= 100%) | 82 |

Note: Several women gave more than one reason.

Source: A. Cartwright & C. Lucas, 'Survey of abortion patients' in *Report of the Committee on the Working of the Abortion Act*, vol III (HMSO, London, 1974), p. 62.

166. There is no full-scale study of young Australians and their contraceptive practices. A study of women students at Melbourne University found that few failed to take any precautions at all but that many relied on unsafe methods such as rhythm or withdrawal.⁹³

167. A study of 110 male students, conducted in 1975, showed that ten had failed to use some form of contraception in a steady relationship (with the pill and condom far

93. Submission 556, Cole & Beighton.

exceeding other methods). In casual relationships the occasions of unprotected intercourse were higher, and the reasons given for this included:

- belief that it was the woman's responsibility
- youthfulness and inexperience
- opportunity—'it just happened'
- commencing a relationship
- cessation of use of pill⁹⁴

168. A study of 2000 London teenagers in the mid 1960s asked those with sexual experience whether they had taken precautions. Less than half the boys always used some form of birth control and one-quarter had never used any method. Only 20 per cent of the girls always used birth control and 60 per cent never did. Only one-third of the girls always insisted on their partner taking precautions. They nearly all depended on the man. Methods mentioned were: sheath (78 per cent), withdrawal (40 per cent), diaphragm (14 per cent) and chemical methods (9 per cent).⁹⁵ The author comments:

... the girls have a very real fear of pregnancy and yet they do almost nothing to take precautions.⁹⁶

He concludes that about half the groups have very little interest in birth control and will be slow to profit from instruction.

A few boys (5 per cent) and girls (7 per cent) did not know enough to be able to make use of birth control methods. Religious reasons for not taking precautions were given only rarely (6 per cent) by the girls and hardly ever (1 per cent) by the boys. It is clear from the results reported in this section that many of the girls who are having pre-marital sexual intercourse are running the risk of becoming pregnant. Likewise many of the boys are not making use of birth control. Some would be more likely to take precautions if contraceptives were more readily available, but the majority are either not aware of the risks, or at the moment of sexual excitement are not disposed to consider the consequences of an unwanted pregnancy. As sexual intercourse within marriage is socially accepted, it is not too difficult to make preparations and have contraceptives available. But pre-marital intercourse is discouraged, and therefore, when it does take place, it is unpremeditated and clandestine; in these circumstances birth control is less likely to be practised. Unfortunately the consequences of an unwanted pregnancy are far more serious for the unmarried than for the married.⁹⁷

169. An American study of US adolescents aged 15–19, carried out in 1971, reported that the main reasons for non-use of contraception are that intercourse is in the safe period, that intercourse is too infrequent for pregnancy, or that access to services is difficult.⁹⁸ Young people are likely to misunderstand such things as female fecundability, and to have false beliefs, e.g. that the risk of pregnancy from infrequent acts of intercourse is lower than it actually is. There is an urgent need to develop special programs for young people.

Conclusion

170. Without necessarily qualifying the different reasons for failure to use contraception or placing them in any special order they appear to be grouped as follows:

- (a) Ignorance or misinformation about conception, or safe period, or about the risks of infrequent intercourse.

94. Beighton & Cole, Attitudes of young males to contraception, Commission research report, no. 5, 1976, pp. 6/14–6/17.

95. Schofield, pp. 87–91.

96. *ibid.*, p. 91.

97. *ibid.*, p. 93.

98. Shah, Zelnick & Kantner, 'Unprotected intercourse among unwed teenagers', *Family Planning Perspectives* 7, 1 (1975), p. 43.

- (b) Lack of access to services or supplies, or absence of supplies.
- (c) Religious objection of self or partner.
- (d) Fear of doctor or refusal by doctor.
- (e) Unpreparedness for sex on the occasion or in the relationship.
- (f) Failure of partner to take precautions when expected to do so.
- (g) Fatalism, risk taking and impulse.
- (h) Inertia, too much trouble.
- (i) Dislike of interfering with sex.

171. In a situation of such complexity there is no one way to ensure full contraceptive protection for women who do not want to become pregnant. A program would have to provide education, motivation and access. Attention would need to be given to each of the reasons outlined and also to groups with special problems, including migrants, poor people with large families, young single people and those for whom existing methods are not acceptable for one reason or another.

172. The nature of the relationship can also affect the attitude to contraception and its accessibility. People who are married or who have a steady relationship should have less difficulty in contraceptive practice than those involved casually. The pill, the IUD and the diaphragm are methods which imply a steady relationship. In a casual relationship the condom or withdrawal are more likely to be available. These factors are particularly important in planning for young single people.

The male role in contraception

173. Several commonly used methods of contraception—the condom, withdrawal and periodic abstinence—depend upon the man, his knowledge and his willingness to co-operate. Vasectomy has become more common, though its use is usually limited to couples who have completed their desired family size.

174. Most family planning services are designed for women. Female methods often require prescription or other specialist advice whereas male methods do not require prescription, though they often require knowledge and instruction. The shift of emphasis toward the pill and the IUD and away from male methods is a significant cultural change. Not only does it give the woman control over fertility; it means that to become pregnant a positive choice needs to be made, rather than leaving it to chance.

175. Within marriage or a stable relationship some women still depend on their husband for contraception; the extent to which they do so may vary with educational and cultural factors. The less well educated and migrants are more likely to be using withdrawal. We were told that Greek men take pride in treating their women right by withdrawing whereas Australian men generally dislike making any effort. Unfortunately withdrawal is not one of the most effective methods even when properly used. To improve contraceptive practice among migrants special efforts would be needed which take account of cultural factors.

176. The husband's failure to use a method properly can be a factor in unwanted pregnancies. His objection to his wife's use of contraceptives is another problem. The Preterm study noted:

The case of the Yugoslav husband who refuses to allow his wife to use oral contraceptives or an IUD because of fears of marital infidelity is not uncommon.⁹⁹

There are instances known to FPAs in which a husband refuses to allow his wife contraceptive advice and, should she obtain this, attempts to throw away the supplies or even to remove the IUD. Where partners are in disagreement about family size the method of contraception may become a source of conflict.

177. The Poverty Commission noted that:

For some men, getting and keeping their wives pregnant is a means of overcoming fears of personal insecurity or of affirming their virility.¹⁰⁰

178. Because the condom is available free of prescription (and would under our recommendations be more widely distributed) and as its use is a preventive measure against VD, it is a particularly valuable method of contraception for young single people who may become involved in casual relationships. In 1935 Dr Marie Stopes wrote that the condom has a place in contraception 'but not for long-continued use, only for temporary use and for special occasions'.¹⁰¹ Her comments are still valid.

179. Unfortunately the condom is not always popular. The survey of male university students reported that many men commented that it reduces sensation or that it seems a cold-blooded or unaesthetic approach to sex.¹⁰² It is interesting to observe that we have heard that in some other countries, e.g. Japan, the condom is acceptable and popular. It is possible that ways could be found of overcoming attitudes resistant to this method. This is important in view of its general usefulness in casual relationships and its ready availability.

180. Educational and motivational programs should include the male and especially the young male.¹⁰³

External constraints

Access to services

181. Some people have difficulties in obtaining contraceptive advice and supplies because of the hours they work or because they live in an area without facilities, e.g. in remote and rural communities. One witness was asked: 'Are the health problems of country people being adequately dealt with?' and she replied:

They are adequately dealt with where there is a doctor or enough doctors to service the community, but doctors are very reluctant to go to country areas . . .

Their time is overtaxed and their knowledge is limited. One thought that we did have was that the mobile units have been very useful in the past for the services they have lent themselves to, and it was suggested that perhaps the mobile units could be used in centres for say family planning or information for alcoholics or help for any of the people who can't be dealt with satisfactorily by a doctor or by a minister.¹⁰⁴

182. In some rural areas, where the only doctor refuses to prescribe certain kinds of contraceptives or only prescribes to married women, contraception is virtually excluded from certain sections of the community except for condoms supplied by the local barber or chemist. People living in remote areas away from towns must rely on visiting health teams and flying doctor services. It is difficult for them to obtain follow-up advice or lengthy instruction at the time of prescription. Many women are reluctant to raise the subject of contraception on two-way radio which affords no privacy.

100. *Social/medical aspects of poverty in Australia*, p. 153.

101. Stopes, p. 116.

102. Beighton & Cole, Commission research report, no. 5, pp. 6/25, 6/29.

103. For further comments about fathers, see Cartwright, pp. 156-7.

104. Evidence, pp. 1898-906, Barbara Dinnie.

183. In cities and towns the problem of access to contraceptive services is less acute, but there are still areas where there is a shortage of doctors and no FPA or other clinic. In these areas, contraception may be refused by some doctors and chemists. Poverty, shift work or too many young children are some of the factors which prevent people from getting to the services which do exist. Limited clinic and surgery hours militate against a woman who works long hours or whose husband works alternate shifts with her, because there is no one at home to mind the children while she attends for an appointment. Transport costs may also be a factor. Sheer exhaustion, the lack of a telephone and the unfamiliarity of the procedure or lack of privacy at the surgery or clinic may all deter potential clients.

184. The costs of filling the prescription or of supplies may be too great or at least it may mean that the visit is put off for a while. The opening hours of pharmacists can also be an inhibiting factor. All these factors are exaggerated where there is also a language problem.

185. Better distribution of contraceptive services is needed both geographically and in hours of access. For example, people who are harassed by personal difficulties may only be able to find time to go for contraceptive advice at the weekend or at night, other people may be deterred by a rigid system of appointments and feel more at home at a place where they can just 'drop in'. Provision for out-of-hours supplies is needed. More field workers are called for in the remote and rural areas of Australia with special training in contraception and the related areas of gynaecology and sexuality.

Medical attitudes

186. Medical attitudes were said to be off-putting, particularly to young people. According to Wainer:

. . . the lack of effective contraception among some young women was because they were reluctant to approach a doctor . . . Of the teenagers in the FCC sample, 10 per cent said they were either too scared to see a doctor about contraception or they did see a doctor and were refused contraception. More than half of the teenagers were ill-informed about the necessity for and the various methods of contraception.¹⁰⁵

Opposition by medical practitioners is frequently associated with the doctor's religion (or views about womens roles and morality) and is generally declining. There still remains a need for medical practitioners to be better informed about contraception, particularly about the management of side effects of the pill and the alternatives to this method. In our 'unwanted pregnancy phone-in' we had this comment:

My doctor told me I didn't need to know anything about that sort of thing . . . he made me feel rather dirty for wanting to know such a thing.

Other constraints

187. Crises in people's lives often intervene in contraceptive use.¹⁰⁶ They take an individual's attention away from ordinary tasks, including the obtaining or use of contraception. Parental intervention may constrain a dependent daughter even where her sexual activity is already known. A case was reported to us of a daughter, aged 18 (legally of age), who was told to leave her parents' house after a packet of contraceptive pills had been found in her handbag.¹⁰⁷ Less specific constraint may occur through nagging, moralising, disapproval and rejection by parents, friends and relatives.

105. Wainer, *La Trobe Sociology Papers*.

106. W. B. Miller, 'Psychological vulnerability to unwanted pregnancy,' *Family Planning Perspectives* 5, 4 (1973).

107. FPA NSW, in personal consultation with Commission research staff.

188. Pressure may also be applied by the representatives of certain religious groups, pressure groups, ethnic groups, other institutions (e.g. schools, orphanages and hospitals) and professional groups, especially the medical and paramedical professions. Pressure may be applied in personal contact, as in a sermon or professional consultation, or via the media. For some women this occurs at the point of request for service.

Motivational factors

The intra-psychic theories

189. Sandberg and Jacobs in an article which is frequently quoted consider that:

... women are ambivalent about pregnancy throughout most of their reproductive lives. Psychic conflict regarding contraception is to be anticipated, as conscious and unconscious reasons for and against its use exist simultaneously.

and further:

A physician who accepts proffered statements for the whole truth is soon confounded by the apparent irrational action of some patients in their misuse or rejection of the prescribed contraceptives and by the unreasonable and inconsistent explanations as to why none of the various methods are utilisable . . . It is obvious that behaviour in contraceptive use does not always conform to apparently rational, externally voiced attitudes and that conflicting psychological forces, conscious and unconscious, are extremely influential.¹⁰⁸

190. Raphael has also written of 'self-punishment' and 'self-destruction', depression and hostility in this context.¹⁰⁹ She also suggests that, before prescribing the pill, the doctor should assess the patient's current family life, motivations and abilities for parenthood or contraception, current or recent situational stresses or life crises and any notions of fantasy families.¹¹⁰

Often the female subconsciously or consciously does wish a pregnancy to escape from a set-up she will not tolerate, or on the other hand it is needed as an expression of self-esteem. Again it may fulfil her own love needs in this way, at other times it seems to be a chosen form of martyrdom. Also to some the risk is half the excitement of sexual encounter, and probably this is also the cause of the loss of libido encountered with some of the contraceptive methods used in these persons.¹¹¹

Similarly, the Perth Catholic Family Welfare Bureau wrote:

It is considered noteworthy that in the experience of the agency with unmarried mothers every case showed evidence of disturbance of the background of the girl concerned. A common factor was a feeling of being left out and unloved by the parents. A deprived childhood usually results in a poor self-image, which predisposes the girl to gratefully over-react to expressions of admiration, love etc., from the opposite sex.¹¹²

191. We agree that doctors should listen carefully and sympathetically to their clients and be receptive to indications of stress or difficulty. We doubt, however, that inadequate contraceptive use in the general population can be explained by these hypotheses. It seems to us that lack of information, misinformation and social and cultural constraints explain a greater proportion of non-use than do individual personality disorders.

108. Sandberg & Jacobs, p. 228.

109. B. Raphael, 'Psychosocial aspects of induced abortion, its implications for the woman, her family and her doctor', parts 1 & 2, *MJA*, 1 July 1972 and 8 July 1972.

110. B. Raphael, 'Primary care and the prevention of psychiatric disorder', *Australian Family Physician* 5 (1976), p. 1087.

111. Submission 924, Dr A. D. J. Stoutjesdijk.

112. Submission 1122, Catholic Family Welfare Bureau; see also Dr R. H. Griffith, 'Pregnancy as a symptom of emotional disturbance (delivered at seminar on 'Family planning and the law', Monash, July 1976).

192. The intra-psychic theories of contraceptive use are based on the clinical experience of psychiatrists and supported, in the submissions, chiefly by agencies assisting women with problem pregnancies. Neither group of professionals see a cross-section of the population and people seen by psychiatrists are not necessarily representative of the wider, sexually active and fecund population. The needs, conflicts, wishes and fears that their patients have may occur in other people to a greater or lesser degree. Where they do occur the personal problem may not readily be resolved simply by providing effective contraception.¹¹³ They are not in our view the critical factors in general contraceptive behaviour.

Role conflict

193. There is no doubt that some people experience conflict about the use of contraception or about a particular method. Sometimes this arises from assumptions and expectations about the roles that people adopt at varying times in their lives. In the teenage years, and to some extent pre-maritally, there frequently occurs conflict over the decision about whether to be a sexually active person or whether to conform to the traditional role requirements of propriety and sexual sublimation. This is typified by responses in some of the surveys to the effect that the woman had not expected sex in the relationship and was not prepared for it. The other side of this answer may be the feeling that to be prepared is not proper: 'Nice girls don't.' Most teenage girls receive little explicit assistance here. The South Australian Medical Womens Society wrote:

. . . many girls feel that to plan ahead for sexual intercourse makes them somehow more guilty than if it occurs when they are momentarily overwhelmed by emotion.¹¹⁴

194. Other role conflicts exist for the married woman. Typically this is the choice between being a working woman and a mother to the extent that these are seen as mutually exclusive roles. Ambivalence about this question may result in indecision, in ineffective contraception or in choice of an ineffective method. It has not been demonstrated, however, that indecisiveness is the determining variable in inadequate or ineffective contraceptive use. Uncertainty about whether or when to become pregnant affects some people. But among those who would clearly prefer not to become pregnant there are external factors which inhibit their choice and use of effective methods.

Other factors affecting motivation

195. Women are sometimes ambivalent about their desire to avoid pregnancy as well as uncertain or ignorant about appropriate means of contraception. Certain factors can influence motivation and lead to more effective contraception.

196. A number of reports assert, for example, that contraceptive use improves after abortion. For example, an English study of abortion patients at Kings College Hospital found significant improvement in contraceptive use at 3 months after termination, as shown in table IV.14.

197. Two of the major abortion clinics in Australia report that choice of contraceptive method after abortion reflects increased use of the effective methods and a decline in use of the unreliable methods.¹¹⁵ The data from the Preterm clinic indicate that only 37.6 per cent were using contraception at the time of conception, including 4.4 per cent using oral contraceptives, 4.4 per cent using the condom and 11 per cent using coitus interruptus alone. The report comments on the type of contraception planned.

113. K. C. Luker, *Patterns of pregnancy: towards a theory of contraceptive risk taking* (thesis, Yale, May 1974).

114. Submission 143, SA Medical Womens Society; see also The Boston Womens Health Book Collective, *Our bodies our selves* (Simon & Schuster, NY, 1973), p. 109.

115. Submission 73, Jo Wainer.

Table IV.14 Contraceptive use among 326 women who attended follow-up clinic 3 months after termination

| After termination | Before termination | | | | Total | % |
|-------------------|--------------------|------|------|------|-------|------|
| | A | B | C | D | | |
| A | 33 | 55 | 34 | 159 | 281 | 86.2 |
| B | 0 | 5 | 1 | 10 | 16 | 4.9 |
| C | 1 | 1 | 5 | 3 | 10 | 3.1 |
| D | 1 | 3 | 1 | 14 | 19 | 5.8 |
| Total | 35 | 64 | 41 | 186 | 326 | 100 |
| % | 10.7 | 19.6 | 12.6 | 57.1 | 100 | |

Key to method of contraception: A = pill, IUD, combination or sterilised; B = cap, sheath; C = foam, pessary, safe period, coitus interruptus; D = none.

Source: Beard et al., 'Kings termination study 2: contraceptive practice before and after outpatient termination of pregnancy', *British Medical Journal*, 9 March 1974, p. 420.

Most women at the time of the termination stated that they would use oral contraception (71.8 per cent). A much smaller percentage (12.4 per cent) preferred an IUD, and 8.3 per cent intended either to have a tubal ligation or their partners would have a vasectomy. A very small proportion (3.3 per cent) chose to continue with other methods, such as a diaphragm or condoms—with or without spermicides—rhythm or coitus interruptus. Only 4 per cent of women were undecided.¹¹⁶

198. A more recent follow-up of Preterm and Population Services International clinic patients found that 85 per cent of women responding were using effective methods of contraception 6 months after they had had an abortion.¹¹⁷ Unfortunately the response rate for this study was poor. Preterm clinic reports a return abortion rate of about 5 per cent. The need for contraceptive services for abortion patients is clear.

Conclusions

199. The picture is a complex one. Variables affecting contraceptive practice are not necessarily reflected in the pressures which lead to abortion. Programs for the whole community to improve knowledge and use of contraception should emphasise the young and single, and those whose cultural and ethnic backgrounds result in ineffective contraception and make access to services difficult. Poorer groups also need special attention.

200. Effective contraceptive use depends on information, motivation, beliefs, access to services and on other personal and external factors such as the nature of the relationship and attitude of the partner. Many changes are needed before it could be said with confidence that all who wish to avoid pregnancy have the knowledge and means to do so.

Contraceptive services

Introduction

201. At present most contraceptive services are provided by medical practitioners or by voluntary organisations, both operating in the private sector. The present services

116. Snyder & Wall.

117. C. Anthony, E. Berman, L. Hart, S. Raymond, D. Richardson, K. Richardson, W. Robilliard, T. Sangster, Abortion: a survey six months later (student assignment, Department of Preventive & Social Medicine, University of Sydney).

are inadequate in some respects and do not reach many people who need them, because of cultural barriers, distance, cost and other factors. Governments are becoming aware of the need to improve and extend these services, but have not made a full commitment to do so as yet.

202. Laws still operate to inhibit services; publicity is inadequate. There is a real need for comprehensive government policies to develop and extend existing services, and to inform and motivate people to make use of them.

203. The pattern of services has been mainly a medical pattern because so many contraceptives require a prescription, or fitting by or under the supervision of a doctor. Services have been mainly designed for women. These patterns are beginning to change. The multidisciplinary nature of contraceptive services is being recognised along with the need for communication between teachers, doctors, nurses and social workers depending on where and in what circumstances the need is identified.

204. We consider existing services with a view to making recommendations to ensure equal access by all to effective contraception. Contraceptive services are one aspect of fertility control services which assist men and women to plan and space the number of children they produce.

205. Units offering contraceptive services also frequently provide other services. These may be a general medical service; pathology tests; treatment for infertility, illnesses of menopause, VD and other sexually transmitted diseases; counselling and referral. Abortion services also offer a range of other services, including contraception.

General practitioners and gynaecologists

206. There are more than 7000 general practitioners in Australia and 716 gynaecologists. They provide contraceptive services for the greatest number of users. The Poverty Commission reported that 84 per cent of women sought contraceptive advice from a general practitioner, specialist, or hospital doctor, as distinct from family planning clinics.¹¹⁸

207. The general practitioner is considered by many to be the ideal person to dispense these services. Some forms of contraception are available only through a medical practitioner. For example oral contraceptives are available only on prescription, and the IUD and diaphragm must be fitted by a doctor. Sterilisation has to be performed by a doctor.

208. In a submission the Australian Medical Association stated:

Freely available contraceptive advice and counselling and free access to contraception is urgently required to solve the present and future problems of our community. Where possible the ideal provider of family planning advice is the doctor.¹¹⁹

General practitioners are widely (although not uniformly) distributed throughout the country. They tend to be more accessible to the client than any other service; they often know the patient's background and medical history which can be taken into account when prescribing contraception. The GP is also well placed to initiate discussions about family planning and to provide continuing care.

118. *Social/medical aspects of poverty in Australia*, p. 142 (the information is based on a research report).

119. Submission 1101, AMA.

209. Two Australian surveys have investigated contraceptive services as provided by general practitioners. The Barson and Wood survey of 113 GPs (1972) discovered that all the GPs who responded to their survey 'gave advice to patients on family planning' (65 per cent of the entire sample).¹²⁰

210. We conducted a survey of 1150 GPs in 1976 (see Annexe III.A). All but eight GPs (who did not answer the question) claimed that they were consulted each week about family planning. More than half of these, however, claimed that such consultations would involve less than 5 per cent of their patients in one week. For nearly all the remaining GPs contraceptive advice was requested by no more than 25 per cent of patients in any one week. Doctors over 60 years of age were less likely to be consulted on this matter than were younger doctors.

211. There are, however, some disadvantages about the GP as a source of contraceptive advice. Some practitioners are unwilling or untrained to give contraceptive advice or the full range of advice. The Barson and Wood survey included four Catholic doctors who would not prescribe the pill and thirteen who would not insert IUDs. Further, seventeen of their respondents would not give contraceptive information to unmarried patients, Catholic doctors being less likely to do so. Only two doctors would prescribe contraception for an unmarried minor without parental consent, although this may reflect a fear of flouting the law and a concern that prescription of oral contraceptives may be contra-indicated for very young women.

212. In our survey of 1150 GPs, seventeen doctors had not recommended the pill to any patient during the previous 12 months; sixteen of these doctors were Roman Catholic. One hundred and forty-nine other GPs who were Roman Catholic had, however, prescribed the pill. With the exception of the diaphragm, spermicides, withdrawal and abortion, more Catholic doctors had recommended each method of contraception than had not recommended them. There was no religious differential in the general unwillingness to recommend withdrawal. On the other hand, proportionately more Roman Catholic doctors recommended calendar rhythm and temperature methods and the ovulation method than did doctors of any other religion.

213. In general, as Table IV.15 demonstrates, general practitioners favour those methods of contraception which require a doctor's surgical or prescribing skills. Oral contraceptives, the IUD, vasectomy and tubal ligation are recommended by more GPs than condoms, diaphragms, spermicides and other methods. Nearly 50 per cent of the GPs sampled had recommended abortion for at least one patient during the previous 12 months. While withdrawal was rarely recommended, the other less reliable methods, rhythm, temperature and ovulation, were recommended by at least a quarter of GPs sampled. Although there was a religious differential, not all doctors recommending these methods were Catholic.

214. We also sought to discover how often general practitioners themselves initiated the subject of family planning during consultations. Eight situations were presented to the responding doctors and, with regard to each, they were asked to indicate whether they routinely raised the subject of family planning. The percentages of responses to this question are shown in table IV.16.

215. The results in table IV.16 indicate a reasonable awareness that family planning is appropriate in the situations mentioned. It is not certain, however, that every patient will be offered contraceptive advice in those situations. Clearly a small proportion of doctors feel that this subject should be left to the patient to raise.

120. M. Barson & C. Wood, 'A survey of the general practitioner in family planning', *MJA*, 20 May 1972, pp. 1069-71.

Table IV.15 Percentage distribution of responses to the question: 'Have you recommended the following family planning methods in the past 12 months?'

| Method | Area of practice | % GPs recommending method in last 12 months |
|---------------------|------------------|---|
| | | % |
| Oral contraceptives | metropolitan | 98 |
| | country | 98 |
| IUD | metropolitan | 85 |
| | country | 85 |
| Condoms | metropolitan | 70 |
| | country | 64 |
| Spermicides | metropolitan | 65 |
| | country | 63 |
| Diaphragm | metropolitan | 42 |
| | country | 38 |
| Rhythm | metropolitan | 42 |
| | country | 38 |
| Ovulation | metropolitan | 27 |
| | country | 34 |
| Withdrawal | metropolitan | 5 |
| | country | 5 |
| Abortion | metropolitan | 49 |
| | country | 47 |
| Vasectomy | metropolitan | 79 |
| | country | 83 |
| Tubal ligation | metropolitan | 83 |
| | country | 87 |
| Abstinence | metropolitan | 14 |
| | country | 13 |

Table IV.16 Percentage distribution of responses to the question: 'Do you raise the subject of family planning as a matter of routine in any of the following situations?'

| Situation | Area of practice | Yes | No | No consultations on this matter |
|---|------------------|-----|----|---------------------------------|
| At 6-week post-partum check-up | metropolitan | 72 | 7 | 16 |
| | country | 84 | 9 | 6 |
| At a pre-marriage consultation | metropolitan | 84 | 6 | 6 |
| | country | 82 | 8 | 6 |
| At a first gynaecological consultation | metropolitan | 61 | 28 | 4 |
| | country | 58 | 32 | 3 |
| As a normal part of history taking | metropolitan | 53 | 37 | 1 |
| | country | 52 | 40 | 1 |
| At a rubella vaccination | metropolitan | 65 | 21 | 6 |
| | country | 61 | 26 | 7 |
| At a request for abortion | metropolitan | 86 | 6 | 3 |
| | country | 82 | 10 | 4 |
| At discussions of sexual/marital problems | metropolitan | 90 | 6 | 1 |
| | country | 90 | 5 | 2 |
| At discussions concerning venereal or vaginal disease | metropolitan | 66 | 27 | 2 |
| | country | 67 | 25 | 3 |

Percentages do not sum to 100 owing to rounding and a small number of responses not identifiable by area.

It is interesting that 90 per cent of responding doctors said that they raised the subject of contraception when consulted for sexual and marital problems, but fewer did so at other appropriate times such as before marriage and at the post-partum check-up. Although it is essential for a woman having a rubella vaccination to avoid pregnancy for at least 3 months after the vaccination, 21 per cent of metropolitan doctors and 26 per cent of country doctors said they did not routinely raise the matter of contraception in this context. One in four of the doctors did not raise the subject of contraception at a first gynaecological consultation or at consultations concerning venereal or vaginal disease. Only half thought that contraception should be raised as a routine part of history taking.

216. The situations listed in table IV.16 are all opportunities for preventive health care. There is a good case to be made for giving contraceptive advice routinely in order to identify those who are ignorant and at risk or likely to be at risk in the near future. As long as sex education is not universal, routine intervention by the medical practitioner goes some way to giving each individual access to information and services.

217. Another disadvantage of the GP service is that, until very recently, contraception and abortion did not feature as part of undergraduate medical training. Our survey found that of the 1150 respondents, only thirty-three had obtained certification from a Family Planning Association, and ninety-seven had obtained a post-graduate qualification which required work in gynaecology. Since training in contraception was only recently made a part of gynaecology training, some of these ninety-seven doctors may not have received any formal instruction. Altogether 885 of the 1150 doctors thought that undergraduate training in family planning had been 'inadequate'. Although this situation is being remedied by the medical schools, there will be a considerable time lag before the majority of general practitioners are trained in contraceptive techniques.

218. The position is similar for gynaecologists. Although less widely distributed than general practitioners, they are nevertheless geographically more widespread than, for example, Family Planning Association clinics. However, training in contraceptive techniques became a requirement for membership of the Royal College of Obstetricians and Gynaecologists only for doctors commencing training in 1975. For diploma candidates the date was May 1976.

219. A number of submissions complained about the manner of delivery of this service by some doctors. These complaints recorded instances of censure, moral lectures, outdated information about sexual matters, misinformation, unwillingness to refer and refusal to acknowledge side effects of oral contraceptives as pharmacologically caused.

220. For example, Yvonne Foster, president of the Upwey branch of the Humanist Society, Victoria, claimed that when young girls seek contraceptive advice some doctors are likely to lecture them and tell them to bring their mother.¹²¹ This, it is said, may result in the girl not having contraceptive protection despite her own responsible attitude. This submission suggested that doctors are unreceptive to complaints about the effects of the pill. We have not investigated individual complaints and would not assert that they are representative of the profession as a whole. Nevertheless we are of the view that where a doctor disapproves of contraception as a matter of principle, there is an obligation to refer to other appropriate services.

121. Submission 535, Yvonne Foster; see also Submissions 775, Dr J. Lumley; 619, ALRA, NSW; C725, confidential; 73, Jo Wainer; 210, WEL, Victoria.

221. A further impediment to effective service delivery is that the general practitioner is usually unable to provide the range of services offered elsewhere, for example by Family Planning Association clinics. These include pathology services on the spot and trained counselling services covering such topics as abortion, psychosexual problems and menopause. Counselling is a skill which is not taught adequately in medical education. The general practitioner is usually unable to devote the time to an individual patient that doctors and other staff in clinics may be able to give.

222. Finally there is the issue of the medical role in contraception. The AMA view is that:

Whilst training paramedical personnel can be of great assistance in conserving medical manpower, the ultimate decision for each patient's contraceptive needs must be made by the physician.¹²²

This view is not necessarily that of all GPs. Medical considerations affect the use of a particular method of contraception for only a minority of people and medical indications apply only to a few methods (although these are the methods most frequently recommended by doctors). People consult general practitioners for advice but, in most cases, the decision about the method should rest with the individual client, after proper information and advice; the doctor's role is to exclude those methods contraindicated for that person.

223. There is a continuing role for the GP and gynaecologist in the delivery of family planning services. Improvements in medical education should help in the long run to develop new and less authoritarian attitudes on the part of some doctors. There remains a need for other kinds of service. Much of the provision of contraception involves counselling skills and medical techniques which can be competently handled by paramedical staff (papanicolaou smears, breast examinations, pregnancy tests, repeat oral prescriptions and IUD insertion). Other professionals, such as district nurses, social workers, teachers etc., all have a part to play in identifying persons in need, in giving information, in counselling and in referring to contraceptive services. These services can no longer be considered as the exclusive domain of the medical practitioner.

Family Planning Associations

224. Family Planning Associations are voluntary organisations providing a major source of contraceptive services along with private medical practitioners. There is one Family Planning Association in each State and Territory. There is a co-ordinating body, the Australian Federation of Family Planning Associations.

Nature and scope of services

225. Family planning clinics of the Family Planning Associations (FPAs) are the main alternative to the general practitioner or gynaecologist for a person seeking contraceptive services. Many people prefer to attend a clinic. There are a number of reasons for this:

- (a) The clinic provides some anonymity to the patient who is shy about gynaecological consultations or who does not wish to discuss sexual activity with his or her usual general practitioner.
- (b) Some people attend FPA clinics because they wish to avail themselves of a specialised service or because their general practitioner or gynaecologist refuses to prescribe or to advise on the method of their choice.

122. Submission 1101, AMA.

- (c) Each Family Planning Association has a medical advisory board to advise on correct medical procedures and to keep its medical personnel up to date. FPAs hold in-service courses for medical personnel; this is a safeguard not afforded to the patients of most general practitioners.
- (d) The FPAs also offer a number of services in one location (see Annexe IV.F). Five of the seven Family Planning Associations in Australia offer a pathology service. Three (NSW, Vic., ACT) offer vasectomy operations and two (WA and NT) treat VD. All conduct pregnancy tests on the spot and all but ACT and SA treat menopausal problems.
- (e) All Family Planning Associations pay considerable attention to counselling and informing the patient; consultations are frequently lengthy; and there is usually literature to take or buy, and contraceptive supplies to be purchased on the spot. Adolescent and psychosexual counselling is available in nearly all places (see Annexe IV.F).
- (f) Each FPA maintains a list of agencies and individuals to whom patients may be referred. Counselling and referral services cover a wide range of topics: pregnancy, sexual difficulties, genetic problems, infertility, menopause, adolescent sexual development and marriage guidance.

226. FPA clinics offer advantages for those commencing contraceptive use, wishing to change their method, wishing a consultation quickly, specialist advice, or requiring counselling or a sympathetic reception not accorded at their usual source of medical advice. Many patients appear to return to their GP for continuing prescriptions or check-ups.

227. There are some disadvantages of clinic services. A study in England found that significant numbers of women considered that clinics were less accessible than GPs, that it took longer to reach them and they were open at fewer times. Many did not know how long a clinic visit would take or when clinics were open.¹²³ A small survey carried out in Sydney made similar findings.¹²⁴

Distribution of services

228. Table IV.17 shows the distribution of FPA services in 1976.

229. The entire country is catered for by a mere seventy-seven clinic locations of which only fourteen are in country areas. Only 233 clinic sessions operate each week in Australia, staffed by less than 400 trained doctors and nurses. To some extent this picture is distorted, because the Department of Health in Victoria runs its own contraceptive clinics at thirty-seven locations, holding fifty-three sessions per week in that State. Inclusion of these clinics brings the total number of locations to 114, with fifteen in country areas, holding 286 sessions per week, with 418 medical and paramedical personnel.

230. The absence of clinics in country areas is partly due to the problems of organisation for voluntary associations based in the major centres. It is difficult to recruit doctors practising locally who already give contraceptive services as part of their practice. It is also difficult to bring people into the major cities for training. Another problem is that of local hostility, particularly on the part of medical practitioners; one submission

123. Margaret Bone, *Family planning services in England and Wales* (HMSO, London, 1973), p. 6.

124. Carol Hawker and Jenny Banfield, *Birth control services . . . a plan for change. A study of some women 'at risk' of experiencing unplanned pregnancies, in order to devise suitable methods of birth control education and service delivery* (Department of Preventive and Social Medicine, School of Public Health and Tropical Medicine, University of Sydney, 1976).

complained that the patients at a clinic were all from a section of the community which ought to use private medical services rather than from a disadvantaged group.¹²⁵

Table IV.17 Distribution of FPA services, 1976

| Name of organisation | Number locations | Number country locations | Number sessions each week (2-4 h per session) | Number locations open full time | Visits 1975 (1st visit) |
|----------------------|------------------|--------------------------|---|---------------------------------|-------------------------|
| FPA NSW | 39 | 11 | 88 | 2 | 30 944 (9 692) |
| FPA Vic. | 4 | 3 | 28 | 1 | 6 631 (1 772) |
| FPA Tas. | 4 | .. | 6 | .. | 1 365 (312) |
| FPA WA | 7 | .. | 21 | 1 | 6 196 (1 799) |
| FPA Qld | 7 | .. | 35 | 1 | 8 510 (2 030) |
| FPA ACT | 4 | .. | 14 | .. | 4 649 (1 202) |
| FPASA | 8 | .. | 37 | 1 | 14 951 (3 304) |
| FPA NT | 4 | .. | 4 | .. | 916 (381) |
| Total | 77 | 14 | 233 | 6 | 74 162 (19 230) |

231. Because of the special advantages they offer, we favour the establishment of clinic services in country areas. They should be available in a form suitable to the people in the area; in some cases this would be as part of a more general community health service. The most suitable service should be decided for each area in consultation with community members, including those whom the clinic aims to attract, such as the sexually active teenager, the poor, members of ethnic minorities and middle class women who wish to seek contraceptive advice on neutral ground.

Need for expansion

232. Available information suggests that there is considerable scope for the expansion of FPA services. Expansion of existing facilities has usually led to an increase in the number of persons attending the clinics (see Annexe IV.F). Short-term advertising campaigns also bring increased rates of attendance, suggesting that large-scale advertising would further increase the demand for these services.

233. The annual report of the Victorian FPA noted that:

... approximately 47 per cent of all new patients seen at our clinics are under 20 years of age ... approximately 86 per cent of all new patients are unmarried.

Each year a large number of young women become potential clients of FPAs. Many, however, do not use the service (or any other contraceptive service). We estimate an incidence of approximately 100 000 unwanted pregnancies each year in Australia. Many of these occur to young single women. There is a clear need to expand clinic services and to reach out to potential patients who are not using existing services for any reason. This may require identification of target groups, new clinics or new kinds of services.

125. Submission C1263, confidential.

234. The present scattered location of clinics means that some people have to travel some distance to attend them. Because of the emphasis on counselling and information, delays occur. Some people would prefer to see the same doctor at each visit. Many of these problems could be solved if further funding were available enabling clinics to be open more often.

Funding

235. In the financial year 1975–76, Family Planning Associations received funds from the Commonwealth government from up to five sources, and this money provided the bulk of their income (see Annexe IV.F). Although these different sources of funding may have permitted particular projects to be funded, it leads to duplication of time and effort spent on budgets, accounts, applications for funding and reporting to the relevant authorities by the Associations. It would make sense for an entire program to be funded from one source requiring one budget and one set of accounts.

236. The arrangements for the financial year 1976–77 remain complicated. In this financial year clinic operations are funded by:

- (a) A health program grant covering the bulk billing of Medibank standard cover clients and unbillable patients (unbillable patients being those who cannot use the private, family rate insurance cover of their husband/wife or parents for contraceptive services).
- (b) Fees for services paid by clients whose health insurance is covered by private fund, the clients then claiming reimbursement.
- (c) State assistance by means of rent subsidies and free accommodation in baby health or other centres.

237. The education, training and research functions of the FPAs, including the salaries of some senior administrative staff, will be funded by a direct special projects grant from the Commonwealth Department of Health and grants from State governments. The amount allocated by the Department is the same amount expended in 1975–76, and allows no margin of increase due to inflation, nor for expansion. All FPAs will have additional revenue from membership fees, sale of contraceptives and fees for some education and training programs. However, since FPAs keep their fees as low as possible in order to make their services widely available, and since fees are waived for those in need, this source of income is not great.

238. The FPAs now have to meet the additional costs of the new Medibank system of collecting fee for service and refunds. This involves extra staff in accounting sections to cope with payment systems and extra costs for printing new account forms and for training personnel, many of whom work only a few hours a week in suburban locations.

Doctors and nurse practitioners

239. As the FPAs expand to meet a growing demand, they require more doctors. These usually work in sessions lasting 3 to 4 hours. There is a shortage of doctors willing to train in contraceptive techniques and work for a salary in the clinics. It is particularly difficult to find doctors for certain areas, such as remote city suburbs and the country areas. It is important to select doctors who have a sympathetic manner and who are in harmony with the aims of the organisation.

240. In the more remote areas the local practitioners are usually much too busy to give extra time to a contraceptive clinic. Although the majority of them are providing some contraceptive services in their practices, many are untrained and some of their

patients, particularly the young, shy and unmarried, find it difficult to consult them on this matter. Some of these problems could be resolved if it were possible to employ trained nurse practitioners to deliver family planning services.

241. This practice is already established in the USA where nearly all the affiliate organisations of the Planned Parenthood Federation employ nurse practitioners to carry out a wide range of tasks, including physical examinations, pap smears, fitting diaphragms and providing oral contraceptives. About half permit nurse practitioners to insert IUDs and more allow removal. In most cases medical supervision is provided by a doctor on the premises and by written instructions. In a few cases the doctor is available on call or by phone.¹²⁶

242. Family planning nurse practitioners (FPNPs) are employed in other clinics besides the PPF affiliate clinics and this new nursing position is receiving recognition in America.

The new program guidelines developed by DHEW by a task force of health professionals, to be issued in the fall of 1975, establish the category of family planning or obstetrical-gynaecological nurse practitioners and midwives who, with formal training, may function in a family planning project under the supervision of a physician.¹²⁷

The range of tasks is very broad and includes prescribing contraception, fitting diaphragms and inserting IUDs.¹²⁸

243. Family planning nurse practitioners have so far been used to a limited extent in Australia. They have great potential for relieving the shortage of medical personnel and reducing the cost of the service. Their introduction has been impeded because of insurance problems, lack of support of most of the medical profession and inadequate finance. In the NSW FPA, six nurse practitioners have received a training approved by the Association's medical advisory board to perform the following tasks: pap smears, bimanual pelvic examinations, breast examinations, vaginal swabs, repeat oral contraceptive prescriptions and diaphragm fitting. These nurses are under standing orders and there is always a doctor on the premises.¹²⁹

244. Some support exists for the use of FPNPs in Australia, however. Professor Rodney Shearman said in evidence to us:

A woman who is returning for a repeat prescription inevitably has to have this written by a doctor even, under present circumstances, where she has been checked appropriately by a medical graduate. It would be much simpler and much cheaper to have the reissue of it, still on prescription, given by a trained nurse.¹³⁰

In his view IUDs could also be inserted by a properly trained nurse, as in the United States.

245. We consider that nurse practitioners should be given a greater and expanding role in the delivery of all kinds of contraceptive services, under the supervision of a doctor. Greater autonomy may be possible later on in respect of certain services. One

126. M. Manisoff & L. W. Davis, 'Family planning nurse practitioners in the United States', *Family Planning Perspectives* 7, 4 (1975), pp. 154-5.

127. US Dept Health, Education & Welfare, Program guidelines for project grants for family planning, under section 1001 Public Health Service Act, 1975 (mimeo); E. Peterson, Associate Bureau Director for Family Planning, Bureau of Community Health Services, DHEW, 1975 (personal communication with authors of the article).

128. Nurses Association of the American College of Obstetricians and Gynaecologists, *Obstetric, gynaecologic and neonatal nursing functions and standards* (Chicago, 1974).

129. Evidence, pp. 3069-70, J. McLean; see also Meg Flynn, *The family planning nurse practitioner: suggested guidelines for role expansion and utilisation* (presented to NSW College of Nursing, April 1977).

130. Evidence, pp. 3085-6, Prof. Rodney Shearman; see also Submission 73, Jo Wainer.

obstacle at present is the difficulty in arranging medical insurance for persons other than medical practitioners. Nurses do not usually have personal cover and most State nursing associations do not cover members for professional indemnity.¹³¹ FPA's are not in a position to provide indemnity; employees of hospitals or Health Commissions would in general be covered. The concept of family planning nurse practitioners should be supported, and grants made to assist in their training. Nurse practitioners should be employed by Health Departments in community health services, hospital clinics and VD clinics. Proper insurance cover should be arranged.

Other problems

246. In extending their services, FPA's meet certain difficulties co-ordinating geographically widespread clinic sessions. Insufficient funds are available to establish regional operation. There has also been some local opposition to the use of outpatients departments or community health centres for family planning clinics. Funding is also not adequate for community education and professional training, which are essential to effective services. Legal restrictions inhibiting service delivery are considered in the section on law and contraception.

247. These problems require government intervention for their solution. Assuming, as we do, that there is a continuing and growing need for clinic contraceptive services, a policy decision needs to be made as to how they are to be administered.

Womens community health centres

248. In October 1976 there were six womens community health centres in Australia funded by the Commonwealth Department of Health. They provide a diversity of services including contraceptive advice and associated services. No fees are charged.

249. There are three womens health centres in New South Wales, the Leichhardt and Liverpool Community Womens Health Centres in Sydney, and the Mayfield Working Womens Centre in Newcastle. The other centres are in Darwin, Adelaide and Perth. Doctors are employed either full time or on a sessional basis. There have been some difficulties in finding salaried doctors and in establishing satisfactory working relationships between doctors and other staff. Each centre has a full-time, or almost full-time, nurse, who can undertake a number of contraceptive and related tasks, such as vaginal swabs, blood pressure, pap smears, breast examinations and contraceptive advice. Many other services are available.

250. The purpose in setting up these centres was to provide alternative health care for women not wishing to consult a general practitioner, and also to investigate those womens health problems which have attracted little attention from research institutes. The public response to the first centre in Leichhardt was a flood of patients, which may be an indication of the level of dissatisfaction with other forms of health care.

251. A submission from a voluntary welfare worker commented favourably on the atmosphere and on the wide variety of services offered. She mentioned that many women do not understand their own bodies and are afraid to discuss matters relating to sex with their doctors.¹³² Attendance at Leichhardt and the other centres has settled at lower rates. There is now less emphasis on primary medical care and more emphasis on counselling and education.

252. Womens health centres were criticised at one stage for providing abortions. When we inquired, in October 1976, none of the womens health centres were performing terminations of pregnancies.

131. Chairman's Nursing Consultative Committee, report, *The role extension of the registered nurse* (NSW Health Commission, June 1976), p. 24.

132. Submission 821, Mrs B. M. Harding.

253. Another criticism concerned the question of medical standards and efficiency and the delegation of tasks to non-medical personnel. An editorial in the *Medical Journal of Australia* expressed the point:

. . . the dangers inherent in such an organisation should be appreciated. The lack of control over training of personnel and the absence of a medical audit open the way for slipping of standards even if the staff have the best will in the world.¹³³

In their view safeguards would have to be set up if the centres were to become more numerous. While it was accepted that the high motivation of existing staff was some safeguard, this might not continue if staff changed.

254. The Leichhardt Community Womens Health Centre replied that training was provided 'on the job' by the sharing of skills and that doctors were responsible to check that procedures were carried out correctly.¹³⁴

255. It is a public concern that safeguards should exist to ensure that the practice of medicine maintains proper standards. This should, of course, be seen in perspective. Family Planning Associations have medical advisory boards, some have medical superintendents. On the other hand, Dr Lionel Wilson, vice-president of the Australian Medical Association, recently noted an absence of a proper system of review of medical standards in hospitals.¹³⁵ There is also no audit on the activities of the general practitioner except the possibility of prosecution or discipline by the licensing authority for malpractice.

256. Many doctors delegate tasks to paramedical personnel and it is this system which operates in womens health centres. The doctor remains responsible for the scrutiny of medical tasks carried out by these personnel. One difference is that in womens health centres the doctor is also subject to scrutiny by all the members of the team.

257. We consider that the views of the non-medical and paramedical members of the health team can play an important part in any review system of medical practice. At present, however, the doctors at womens community health centres function without the benefit of the peer review system, i.e. review by other members of the medical profession. We consider that clinics funded by governments should demonstrate, by the establishment of a medical advisory board or similar body, that medical practice at their establishment is adequately reviewed by other doctors as well as by members of the health team at the centre, and that this should be a condition of funding. Subject to this, we believe that there is a continuing need for womens community health centres as specialist centres providing primary medical care, counselling and education, and undertaking research.

Community health centres

258. Community health centres throughout Australia are funded by both Commonwealth and State Departments of Health and charge no fees. The services offered by these health centres are diverse. Many do not offer primary medical services, although some rent part of their premises to Family Planning Associations for use as clinics.

259. In October 1976, a total of ninety-seven community health centres were offering primary medical services with the doctor as a salaried member of staff, or working on a fee-for-service basis or leasing one of the rooms at the centre. These centres are, however, unevenly distributed between the States and Territories.

133. Editorial, *MJA* 2, 18 (1975).

134. Correspondence, *MJA* 1, 4 (1976); another supporting letter from Margo Moore appeared in *MJA* 1, 3 (1976).

135. L. Wilson MD, Peer review (paper delivered to the Australian Hospitals Association, National Medibank Seminar, Canberra, 10 August 1976. Available from the AMA, Glebe, NSW).

Number of community health centres offering primary medical care: by State and Territory*

| | |
|-------|----|
| NSW | 8 |
| Vic. | 38 |
| Qld | 1 |
| SA | 13 |
| WA | 11 |
| Tas. | 10 |
| ACT | 7 |
| NT | 9 |
| Total | 97 |

* Excludes health centres for specific ailments, e.g. alcoholism, respiratory diseases and child health centres.

260. Community health centres which offer primary medical services are another source of contraceptive service. Although the service is not specialised, there are some supportive services available at the same location. These may be social worker services, psychiatrists, psychologists, marriage guidance and others.

261. If the community health centres were developed comprehensively they could provide better contraceptive services. They could also employ family planning nurse practitioners to provide contraceptive services to a greater number of people. We believe that their role should be expanded in this way.

Natural Family Planning centres

262. There are 129 Natural Family Planning centres in Australia, compared with seventy-seven FPA clinics. The distribution is:

| | |
|------|----|
| NSW | 35 |
| Vic. | 65 |
| Tas. | 3 |
| WA | 6 |
| Qld | 12 |
| ACT | 1 |
| SA | 5 |
| NT | 2 |

These centres saw some 12 000–15 000 clients during 1975, compared with 24 769 new patients and a total of 74 162 consultations at FPA clinics in the same year. Fifty-eight paid workers were employed in 1976 and over 500 volunteer workers. In addition twenty-five persons, fourteen of whom are in NSW, are named as 'contacts' in the *Directory of Natural Family Planning*. The contact may provide information about where instruction is available or, if the contact is a medical practitioner, may provide instruction.

263. Natural Family Planning centres provide instruction in the periodic abstinence methods and in combinations of them.

Couples are instructed by women teachers, couples or doctors at either private interviews or small group instruction sessions. An essential element of the program is the follow-up interviews with each couple until they are competent and confident of their understanding and application of the particular natural family planning method chosen.¹³⁶

136. Australian Council of Natural Family Planning, *Directory of Natural Family Planning* (1976) obtainable from the Catholic Family Life Program, 245 Broadway, NSW, 2007.

Much of the teaching is done by non-medical and paramedical personnel who have been trained for this work. Consultations do not qualify for a Medibank refund.

264. In 1975-76 the Catholic Social Welfare Commission was allocated \$125 000 by the government, on the recommendation of the Health Department, for the maintenance and expansion of services providing instruction in the periodic abstinence methods of contraception. Because of the present association between Natural Family Planning centres and practice of the Catholic religion, the knowledge that is available at these centres about fecundability and female cycles is not easily accessible to all women. Although some instruction in these methods is available at the FPAs, these associations at present tend to refer clients to the Natural Family Planning centres.

265. Although we do not believe that the ovulation method should be promoted to replace more effective means of contraception, there would be some advantages in providing information and instruction in the method in conjunction with other contraceptive services. It would enable people learning the method to have access to other methods; it could teach couples who want to achieve pregnancy to estimate fecundable days; and it could provide women with an opportunity to learn about their bodies. Some of our submissions supported the inclusion of the ovulation and similar methods in all family planning clinics.¹³⁷

266. We agree with these submissions and believe that the family planning services offered by FPAs and the Catholic Social Welfare Commission should be integrated to avoid unnecessary duplication of administrative training structures. This could be achieved within the framework of a community health service. As a first step Family Planning Associations should receive additional funding to establish instruction sessions in female cycles and in the periodic abstinence methods.

Hospital services

Outpatient clinics

267. Hospital outpatient services were alternative sources of contraceptive services until the introduction of Medibank. Some hospitals had run their own family planning clinics. We were unable to ascertain the present number of outpatient clinics.

268. The Royal College of Obstetricians and Gynaecologists (RCOG) maintains a list of teaching hospitals which have family planning clinics approved by the College for training purposes, for membership of the College or for the College's diploma examination. There are twelve such hospitals in NSW, nine in Victoria, four in Queensland, four in SA, four in Tasmania, one in WA and one in the Northern Territory. These clinics provide training for doctors and have also conducted research in family planning.

269. With the exception of Alice Springs Hospital, all the hospitals are located in capital cities or in large urban areas such as Wollongong and Newcastle. People in country areas are obviously disadvantaged in access to outpatient clinics. We have no information about these clinics.

270. Although other hospitals may have family planning clinics, none of them see enough patients to warrant recognition by the Royal College.

271. A submission by Dr Dorothy Nolan set out some of the difficulties involved in setting up a family planning clinic in a hospital.¹³⁸ She pointed out that in some cases

137. Submissions 180, Australian Council of Catholic Women; 179, St Patricks Parish Council.

138. Submission 81, Dr Dorothy Nolan.

the clinics were established to meet the needs of the RCOG. While commending the College for taking the initiative to help obstetricians and gynaecologists to see fertility control as part of their work, she criticised the way in which the clinics were set up. In some cases key hospital personnel were not involved in planning and there was no clear policy about the role of family planning in preventive medicine. Moralistic, even obstructive or negative, attitudes on the part of some staff were also mentioned as well as the lack of staff and of adequate publicity. She made various proposals to overcome these problems and to involve the hospital in planning for the clinic as a teaching unit and also as a service delivery unit geared to the needs of patients. In her view hospitals should accept family planning services as an integrated part of the work.

272. In general we agree with these suggestions. Hospitals providing obstetric and gynaecological services should, in our view, include the full range of fertility control services as part of their responsibility to their patients. Contraceptive clinics should be given the status and attention of other outpatient clinics.

Maternity and abortion patients

273. It is generally agreed that women who have just delivered a child should avoid another pregnancy for approximately 2 years, for the sake of their health and recovery after pregnancy, and also because of the strain that closely spaced pregnancies may place on relationships.

The shorter the birth interval, the greater the risk of mortality for both mother and child. In fact, even good nutrition and medical care, optimal childbearing age and low parity cannot compensate for the health hazards of pregnancies spaced less than 2 years apart . . . Short birth intervals are associated with increased incidence of severe anaemia and complications resulting from pregnancy and childbirth. Also, short birth intervals are associated with an increased incidence of premature births and perinatal mortality.¹³⁹

Other submissions stressed the need of contraceptive counselling for post-partum patients. Dr Nolan saw it as the single most important means of imparting family planning knowledge to patients in hospital.¹⁴⁰

274. Another group of hospital patients who need special consideration in contraceptive services are those women who have just had an abortion. Here the need is not only to preserve health but also to prevent a further unwanted pregnancy.

275. As part of our survey of hospital procedures in abortion cases we asked forty-four large public hospitals about their policies.¹⁴¹ The medical superintendent of each hospital was asked whether it was the policy of the hospital to offer contraceptive advice to abortion and maternity patients, or whether this matter was left to the individual doctor. Fourteen hospitals replied that it was hospital policy to offer these patients contraceptive advice before they were discharged, thirty-one said it was up to the doctor in the case of abortion patients, twenty-three in the case of maternity patients. The remaining hospitals did not answer the question; some of them did not have a maternity section.

276. Speaking of abortion patients, thirty-one hospitals stated that patients 'usually' received contraceptive advice before discharge, nine stated that this information was given only 'on request' and two stated that contraceptive information was not given at the hospital. The figures for maternity patients were twenty-three, nine and two respectively. The main source of contraceptive advice at hospitals for both kinds of

139. Population Information Program, George Washington University, 'Effects of childbearing on maternal health', *Population Reports*, Series J, no. 8 (1975), p. 126.

140. Submission 81, Dr D. Nolan; see also Submission 126, Nursing Mothers Association of Australia.

141. Commission research report, no. 3; the survey has not been written up.

patients was either a staff doctor or a visiting medical officer. In two hospitals social workers were the main source of information for abortion patients prior to the operation, and two used nurses to impart this information after the operation. Nurses were also used by two hospitals for instructing maternity patients.

277. With regard to abortion patients, thirty-five of the forty-four hospitals stated that all methods of contraception were available for their patients; however, five excluded the periodic abstinence methods, one excluded sterilisation and one excluded both of these. The results were similar for maternity patients. This survey covered only the larger hospitals; we have no information about the policies of smaller hospitals.

278. The survey indicated that, with a few exceptions, whether or not a patient receives contraceptive advice is dependent on the doctor. This could mean that patients are not fully counselled about every method, either because their doctor is busy or does not prescribe some methods. Hospitals could use nurses or social workers to provide counselling as part of the hospital routine of after-care for abortion and maternity patients. They could also employ their own or FPA contraceptive educators and possibly achieve further economies by group sessions.

279. A Poverty Commission survey found that less than half the women delivered at the Queen Victoria Hospital attended the family planning clinic for post-natal contraceptive advice, despite the fact that information was given in several languages and an appointment offered.¹⁴²

280. We consider that it is the responsibility of the hospital as part of its service to maternity patients to ensure that advice is offered about contraception, and also services and supplies. Public hospitals should offer instruction in contraception to all post-partum and post-operative patients, thereby making the most of the hospital stay. Where the hospital has no staff trained to provide this service they should sponsor training or arrange for visiting nurses, e.g. from the FPAs, to provide the service.

Contraceptive services run by State Health Departments

281. Victoria is the only State in Australia to make contraceptive services available through its own family planning clinics. The Department runs clinics in thirty-seven locations, most of them infant and child welfare centres. Of these, one is in a country area. At these locations the Department runs fifty-three clinic sessions each week; none of the clinics is open full time.

282. The Department employs twenty-two doctors and twenty-four nurses to staff these clinics. These staff are trained by the FPA Victoria and in two Melbourne hospitals. There are no paid support staff for information, education, counselling or training functions. In Victoria the main educational function is carried out by the FPA and the Department makes little direct provision for this. Department clinics are advertised by notices and literature at the infant welfare centres, advertisements in local newspapers and referral from post-natal clinics, social workers, doctors and nurses, particularly those employed in the infant welfare centres.

283. Compared with the seven FPA clinics which hold twenty-eight sessions per week in Victoria, the Department's clinics see fewer patients per session.

284. FPA and Health Department clinic locations in Victoria catered for only 15 238 consultations in 1975. This compares with 30 944 consultations handled by FPA NSW clinics in 1975. The direct cost to the Victorian Health Department for

142. Reported in *Social/medical aspects of poverty in Australia*, p. 146.

each visit in the financial year 1974–75 was \$8.49 compared with \$5.47 at FPA Victoria and \$6.27 at FPA NSW. The lower attendance figures for Victoria seem to mean that the publicity for the services in Victoria has been less effective. Bolder advertising of the presence of the clinics in Victoria is, in our view, needed. Infant and child welfare centre staff could be trained in a more positive approach. A central appointment system, such as is operated by the FPA NSW, may also improve attendance. It would be ideal if the FPA Victoria and the Health Department could co-operate in the running of the central appointment service.

Table IV.18 Number of visits and number of new patients

| | Visits | | | New patients | | |
|---------------------------|--------|--------|-------|--------------|-------|-------|
| | 1975 | 1974 | 1973 | 1975 | 1974 | 1973 |
| Health Department clinics | 9 607 | 6 586 | 4 571 | 2 991 | 1 886 | 1 272 |
| FPA Victoria clinics | 6 631 | 4 128 | 2 142 | 2 926 | 1 772 | 780 |
| Total | 15 238 | 10 714 | 6 713 | 5 917 | 3 658 | 2 052 |

Source: Victorian Department of Health and FPA Victoria.

285. The situation in Victoria shows that it is not sufficient to open clinics and place trained staff in them if most people do not know they are there. Clinic services provided by a Health Department should be of a standard equal to FPA services. There should be easy access, motivated staff and promotion via advertising, listing in phone books etc. Infant welfare centres are not staffed full time; their staff are not necessarily interested in the contraceptive services provided; and it may be difficult to get an appointment.

Other sources of contraceptive services

The pharmacist

286. Pharmacists supply condoms, spermicidal creams, foams and jellies and diaphragms without prescription and they dispense oral contraceptives on doctors' prescriptions. Logistically they are well placed to provide other contraceptive services, particularly pregnancy testing and advice and referral to agencies.

287. The report of the Select Committee of the Legislative Council of the Parliament of Tasmania on Therapeutic Goods, Health Foods and Cosmetics states:

It was drawn to our attention that many chemists, because of personal convictions, refuse to stock non-prescribable contraceptives. This can cause a great deal of embarrassment to persons seeking to purchase these articles. It seems less than reasonable that a chemist who *does* supply them should not be able to indicate their availability by means of a discreet window sign . . . [A] patient was informed that the two chemists whose business premises were nearest the clinic did not sell non-prescribable contraceptives. She visited in turn four other chemists before the fourth supplied the required items.¹⁴³

288. The Fertility Control Clinic, Melbourne, submitted that there were areas without access to contraception because of the personal attitudes of pharmacists, who have a monopoly on distribution.¹⁴⁴ It was proposed that it should be compulsory for chemists to stock prescription contraceptives and to fulfil prescriptions and that, where local doctors and chemists opposed contraception, FPAs and governments should establish clinics. We would not accept compulsion in this matter.

143. Submitted to the Commission by the FPA Tasmania, Submission 905, Sr Patricia Hewitt.

144. Submission 73, Jo Wainer.

289. A recent survey commissioned by the Australian branch of the IFFPA and the Pharmacy Guild of Australia assessed Australian pharmacists' attitudes to adopting the role of family planning advisers.¹⁴⁵ The survey found that the pharmacist in larger pharmacies tends to regard more highly the importance of providing family planning advice and is more prepared to provide a space for a family planning booth (40 per cent of total). A total of twenty-two interviews were conducted mostly in capital cities and a few in the country. Three-quarters were prepared to do a course to update their knowledge. Most were prepared to provide guidance free of charge. Half thought it was acceptable to display contraception. Although others feared public reaction there was little evidence that this had occurred.

290. There is other support for the pharmacist to play a more significant role in contraceptive services as part of a co-ordinated program.¹⁴⁶ The survey suggests that this could be a useful development. Pharmacist education should include segments on contraception, and refresher courses should be organised by the Pharmacy Guild and the FPAs. Pharmacists should be encouraged to display contraceptive items, or a sign indicating that these are available in the shop. Pharmacists who do not supply contraceptives could display a notice to that effect. The laws regarding the advertising and display of contraceptive items may need amendment.

Community health nurses and community health workers

291. The 1970s have seen the development of a network of community health nurses and community health workers. Some of these are attached to community health centres, some to Aboriginal health programs and others to rural health services, remote area health services etc. The tasks of these nurses and workers varies with the position they hold. In general, those working in country areas have more responsibility for minor medical procedures, and undertake more of the doctors' work than do nurses in urban areas. Training for community health nurses and workers is varied and sometimes includes training in contraception. The Qld, NSW, SA, WA, NT and ACT FPAs all train community health nurses. Very few are trained in Tasmania.

292. We consider that contraceptive services should be an integral part of the preventive health service which these nurses and health workers supply. Both kinds of personnel should be trained to provide information and referrals. More community health nurses are needed to take over a wide range of medical tasks in family planning in remote areas. Legal and other obstacles to the extension of their functions and their ability to act in the absence of a doctor should be progressively removed. A recent research report proposed that community nurses should be trained to find and use opinion leaders in the general community and institutions in their areas and that they should have more time for preventive work.¹⁴⁷

293. The question is sometimes raised whether people attending community health services should be offered contraceptive advice. It is suggested that this might cause embarrassment. On the other hand some people are too shy to ask directly, even though they want help and have no other point of contact. Offering to provide a service should not be considered offensive, provided that the matter is not pressed. Unless the service is offered, some people who want contraception will be denied the service because they are too embarrassed to ask.

145. Survey conducted by Foresearch (unpublished, December 1976); see also M. J. Rumel, L. Reich, L. C. Stringfellow and R. J. Pion, 'The pharmacist's neglected role', *Family Planning Perspectives* 3, 4 (1971).

146. Address given by G. M. Oscar (Monash seminar, July 1976); Evidence, pp. 3069, 3072, J. McLean.

147. Carol Hawker, *Family planning education and services . . . an evaluation of pilot projects* (Dept of Preventive and Social Medicine, Uni. of Sydney, 1977), p. ix.

294. We consider that training in contraception should be provided for and required as a condition of funding for community health nurses and community health workers.

Aboriginal health and medical services

295. Methods of family size limitation are not unknown to Aboriginal culture, though modern methods of contraception are unfamiliar. There is a fear among some Aboriginal people that modern contraceptives, and particularly sterilisation operations, are being used to reduce the Aboriginal population. Some see it as genocide. The infant mortality rate of Aboriginal babies is very high due mainly to poor living conditions.

296. It needs to be emphasised that contraception is a way that individuals can plan the timing of the arrival of children. Decisions about such control should be the responsibility of each individual or couple rather than that of the doctor or nurse, whose function is to advise and to exclude methods not suitable for medical reasons. The Poverty Commission reported that urban Aboriginals in Queensland have an average family size of six–seven compared with the 2.5 average for Australians.¹⁴⁸

297. Some of the problems of providing health and contraceptive services to Aboriginal people in the Northern Territory were described to us in evidence.¹⁴⁹ Because of the fear and embarrassment surrounding contraception, this service is sometimes best delivered by Aboriginal personnel, or through an Aboriginal health service. Each State has an Aboriginal Health Program funded by the Department of Aboriginal Affairs. These programs are staffed by community health nurses and visiting medical officers, who are frequently a source of contraceptive advice. The distribution of these personnel by State is:

| | Community health nurses | Community health workers |
|-----|----------------------------|-----------------------------|
| Vic | 2 | 14 |
| SA | 29 | 50 |
| NSW | 28 | 42 |
| Qld | 59 | 57 |
| WA | 145 | 148 |

There are also eight separately funded Aboriginal Medical Services in Australia, three in Victoria, one in Western Australia, one in Alice Springs, two in Queensland and one in New South Wales. These medical services provide clinic services and also travelling health teams, and in both cases contraceptive services are available.

298. Contraception is an important part of preventive care for womens health. Since the Aboriginal population suffers more serious health problems than the rest of the population, the provision of contraception is essential. It is also important that it be presented to Aboriginal people in a manner which is acceptable to them. There is gradual training of Aboriginal health workers chosen from and by the Aboriginal community. We support such programs to train and employ community health nurses and social workers for each Aboriginal community and in this regard we endorse the recommendation of the Commission of Inquiry into Poverty:

148. *Social/medical aspects of poverty in Australia*, p. 136.

149. Evidence, pp. 2074 ff, S. Wilson.

Special provision should be made for Aboriginal groups to establish their own family planning services in conjunction with general health services. Appropriate resources should be made available to them to enable development of these services along the lines they desire and initiate.¹⁵⁰

Remote areas and the Royal Flying Doctor Service

299. People living in remote parts of Australia are not well provided with contraceptive services. Between May and August 1975 three womens health advisers worked with the Royal Flying Doctor Services in Mt Isa, Broken Hill and Kalgoorlie on a pilot project. The aim of the project was to:

. . . provide information on family planning and problems relating to womens health; increase the level of awareness and expertise amongst the community health and welfare personnel; and to report on the needs of country women and the ways in which these needs could be met.

A Health Department report on the project states that many people had no access to expert advice or information but relied on magazines and word of mouth. Neither parents nor teachers had adequate information. Communications on the radio and by party line were not private. Transport was poor and clinics often overcrowded. Doctors were often felt to be too busy or reluctant to spend time on personal problems. All these problems were greatest for poorer families and Aboriginals.

300. Mobile clinics were suggested by women interviewed, and domiciliary services for people with large families. There was a need for a full-time health educator for Aboriginal women in Queensland. In some remote places there were no pharmacies and supplies had to be sent for. There was little privacy for single people.

301. The report suggested that greater use be made of health educators, including community nurses. They should receive special training and make regular visits to each location. Other nurses should also take on some contraceptive service functions. Doctors should adopt more positive roles in working with health educators and attend revision courses through the Family Medicine Program.

302. The report does not advise direct action by the Commonwealth government.

In each State, action would be necessary through the Family Planning Association, the Royal Flying Doctor Service and the State Health Department. The initiatives might best come from the Family Planning Association.

We have already referred to the difficulties encountered by voluntary agencies in expanding services outside the main centres. Substantial financial support would be needed and an additional administrative burden would be imposed. In our view the initiatives should not be left to voluntary agencies. The Commonwealth government should accept responsibility for the health needs of country women, and should take the initiative to provide contraceptive services in country areas through the community health program, community health educators and the Royal Flying Doctor Service.

Domiciliary workers and mobile clinics

303. Most contraceptive services in Australia operate from fixed locations. Domiciliary workers and mobile clinics, however, move the service to where potential clients are. Domiciliary workers are trained FPA nurses who visit people in their homes. Clients of this service are mainly referred by welfare agencies whose co-operation is essential. The service is mainly educative, but the domiciliary worker may accompany a woman to the clinic to help her to become accustomed to using the clinic regularly.

150. *Social/medical aspects of poverty in Australia*, p. 156.

In the UK, this scheme has also involved home visits by a doctor where the person cannot be persuaded to attend the clinic.

304. Ideally, a domiciliary service in Australia should be prepared to include home visits (covered by Medibank) by a doctor or a nurse practitioner. The program is an expensive one in terms of the number of clients seen and the number of visits required to each client. However there are some people who must be visited if their need for contraception is to be realised. Such people may be physically or mentally burdened by poverty, too many pregnancies and children, by their own illness or handicap or that of a member of the family or by violence or alcohol. Some may have difficulty coping with everyday affairs, others may for various reasons be confined to the house. For the physically handicapped a domiciliary service may be the only possibility of receiving contraceptive services. Such services may also be a way of assisting people who are in institutions for the physically or mentally handicapped.

305. The South Australian FPA is the only FPA which at present provides a domiciliary service. It employs three domiciliary workers, one of whom works with Aborigines. A report by the SA FPA to the Brisbane womens health conference noted that in the first year of operation, the service assisted 302 women who already had between them 478 children. Two hundred and ten of these women were unmarried although some were in stable de facto relationships.

Home visits totalling 1020 were made in the first month while there were 2027 in the second; 712 visits involved transporting the client to a clinic or hospital.¹⁵¹

Their submission argued for an expansion of domiciliary services.¹⁵² Nurses visit to discuss services and they can arrange transport to the clinic. There is some follow-up. The service is seen to help lower socio-economic groups.

306. Domiciliary work should be a part of community health services with home visits made by nurses or health workers. Unfortunately, many do not regard contraceptive services as an important part of their work. Special training and experience are needed to overcome embarrassment. Nevertheless we see this service as part of the general health services which should be available to the community. Funding should be made available for each State FPA to employ at least one domiciliary worker, selected and trained for the position.

307. The South Australian FPA runs a mobile unit. It is an information service that has been located in shopping centres and at community events such as carnivals. While not a medical service the unit is staffed by trained educators from the Association. One of the drawbacks of such units is that they suffer from the same lack of privacy as country clinics. If the unit is clearly identified as a contraceptive service, some people are embarrassed to be seen approaching it. If it is not clearly identified, it cannot expect to attract many clients.

308. Mobile units may, however, have a use as information services. All resource centres and community information centres should carry information about contraceptive services and this should be reinforced by advertising campaigns. Mobile clinics could be used in certain special situations, e.g. to visit factories and other places of employment, or institutions in remote areas and to reach particular groups of people such as Aborigines. We consider that there is a case for setting up a mobile service as a pilot project to demonstrate need and to find the best way of using such clinics.

151. R. Boncant, Domiciliary family planning service (paper presented at IWY conference, 'Womens health in a changing society', Brisbane, August 1975).

152. Submission 148, FPA SA.

Student health services

309. Student health services are now attached to most tertiary institutions and provide students with free health care. Until recently some student health services would not provide contraceptive services. We did not undertake a review of these services, but we believe that most student health services now provide contraceptive services. On at least one campus a separate contraceptive clinic has been set up by an FPA.

310. A research project undertaken for the Commission surveyed the sexual knowledge, attitudes and practices of a group of male attenders at the Student Health Service, University of Melbourne. The results of the survey support the view that sexually active students should, without prejudice, have access to contraceptive services within the student health service. Medical personnel working in student health centres should receive training in sexuality, contraception and sexually transmitted diseases.¹⁵³

Occupational health services

311. We were unable to examine in detail the present system of contraceptive services provided by medical practitioners employed in private companies, and by occupational health nurses. Discussions with a small number of such medical practitioners, however, suggested that contraception is not viewed as an important part of occupational health work nor is the workplace seen as a location for preventive health education. We consider that an opportunity is being missed here for important preventive work.

312. We wish to draw attention to the pioneering work in this field being done by Dr Margaret Raphael, a medical practitioner. She visits some thirty-four work establishments in NSW each year providing an annual health check service for female employees. In a letter to the Commission, Dr Raphael noted:

Work establishments I have visited are: retail 9; light industry 7; food/soap manufacture 5; pharmaceutical 4; office 3; travel-transport 3; textile 1; atomic energy 1; cigarette manufacture 1; printing 1; newspaper-magazine 1; and paint 1.

Over the past 5 years the average number of women examined per annum would be 16 000, 60 per cent of whom would have been checked by me in a previous year, 10 per cent would have had a prior reasonably comprehensive check and 30 per cent no previous check whatever.¹⁵⁴

Dr Raphael estimated that about a third of the women checked asked for contraceptive advice, mainly about the continuation of methods but also with regard to sterilisation procedures.

313. More occupational health nurses are now being trained. We believe the workplace should now be viewed as a location of health care. We agree with the Poverty Commission that contraceptive services should be made available where health workers are employed. This may be one way of reaching migrant women.¹⁵⁵ A recent survey found evidence of a demand for occupational health services, particularly in regard to sexuality and menopausal counselling and as an advisory or referral service.¹⁵⁶ The report proposed that there should be a course for occupational health nurses which included marriage guidance and family planning, including sexuality and menopause, and that an FPA nurse practitioner should spend six sessions with an occupational health nurse in a factory after training.

153. Beighton & Cole, Commission research report, no. 5.

154. Commission correspondence, file 75/1935.

155. *Social/medical aspects of poverty in Australia*, p. 156; see also Evidence, p. 1126, Dr S. Seidlecky.

156. Hawker, 1977, pp. viii-ix.

VD clinics and abortion clinics

314. Contraceptive services are available in conjunction with VD and abortion clinic services. Abortion clinics should ensure that women having abortions are provided with information about contraception and that they are encouraged to leave the clinic with some form of contraceptive protection. We think that VD clinics should make similar efforts.

Policy goals for contraceptive services

315. In our survey of existing contraceptive services we have made general recommendations for further funding and expansion of services at various points where it was felt that the demand for services was not being met adequately. We recognise that there are some groups who need special services to cater for their particular needs. There is also a general need to expand contraceptive services to reach out to those who are not using existing facilities. This need is evidenced by the number of abortions carried out in Australia each year, and is supported by evidence about the number of large families and of families of unmarried mothers living in poverty, as well as by estimates of unwanted pregnancies.

316. Traditionally most contraceptive services in Australia have been provided by private practitioners and voluntary agencies with governments providing some funding; exceptions to this pattern have been public hospital clinics, and State Department-run clinics in Victoria. More recently the government has initiated community health programs providing some clinic services.

317. The policy adopted by the government in 1973 was:

... that all persons should have ready access to family planning advice so that they may achieve the number and spacing of children they desire. The broad objective of this policy is the improvement of the quality of life for both parents and children and the achievement of equality of opportunity for all children.¹⁵⁷

The policy was to be achieved in a number of ways including the funding of voluntary organisations and the establishment of specific family planning facilities where normal methods of access were not available.

318. The current policy of the government is to 'provide more effective dissemination of information to men and women'. The government is seeking to involve the State governments in planning and carrying out family planning programs in each State. Its own role would then be:

- (a) co-ordination of family planning programs at national level to avoid uneven progress or duplication;
- (b) responsibility for research and education;
- (c) support for national and international organisations.

319. Although in the past governments may have been reticent in this area for fear of offending certain groups, there was no evidence among our submissions of any opposition to contraception. Although some groups and individuals favoured certain methods of contraception over other methods, the need for contraceptive information and services to be readily accessible was rarely disputed.¹⁵⁸ Some submissions expressed the view that young people should not have access to services on the grounds that this would encourage teenage sexual activity. We believe, however, that such activity already occurs and will continue to occur with or without the provision of contraceptive services.

157. Cabinet decision, 13 February 1973; Evidence, p. 1116, Dr S. Seidlecky; Exhibit 67.

158. Submission 211, Knights of the Southern Cross.

320. The case for a comprehensive governmental policy on contraceptive services, including the allocation of resources, is threefold: as a benefit for the health and welfare of individuals and families; as a potential for savings in other areas of government expenditure; and as an insurance for equal access by all people.

321. The health and welfare benefits to individuals and families include the following:

- (a) choice of the number and spacing of children;
- (b) better health for women who are relieved of the burden of too many children;
- (c) improved health and welfare for poor families by limiting the number of children;
- (d) benefits to men and women who are able to avoid unwanted pregnancies;
- (e) reduction in the number of unwanted pregnancies and of abortions.

322. In addition to these quality of life issues, there are financial arguments to support an active government role in contraception. The costs of preventing unwanted pregnancies are small when compared with the costs of supporting unmarried mothers, caring for children in homes and providing other help for large families in poor conditions. A report prepared in the United Kingdom in 1972 estimated the benefit-to-cost ratio of providing family planning services as against that of caring for unwanted children during 18 years of dependency. The benefit-to-cost ratio was said to be 128:1 in the case of an illegitimate child, and 22:1 in the case of the fifth child of a family.¹⁵⁹

323. Although no similar study has been done in Australia, a thesis written in South Australia compares the costs of preventing a birth with the public and private costs of child raising.¹⁶⁰

324. Clearly the avoidance of unwanted children is likely to have hidden benefits for public finance, particularly where these children are born to already underprivileged groups, such as poor people with large families and single mothers. Family planning is a cost-effective program for reducing poverty.¹⁶¹

325. In our opinion the government should restate its policy on contraceptive services, viz. that all persons should have ready access to information and advice about conception and contraception and to contraceptive services.

326. To implement the broad policy, and to ensure equal access to services, it is necessary to consider what kind of services should be provided; to identify those groups whose needs are not being met; and to plan for the extension and co-ordination of existing services and the introduction of new services to meet those needs. Programs to inform and motivate people are also needed.

People with special needs

327. There are certain people who do not make effective use of existing contraceptive services. These are the people identified earlier who run the greatest risk of unwanted pregnancies or who are in poor circumstances and tend to have more children than they can cope with. The FPA of South Australia commented that:

The Association is failing to reach migrant women, poorly motivated women and women in the lower socio-economic groups.¹⁶²

159. W. A. Laing, 'The costs and benefits of family planning: a study of the financial implications for the public authorities responsible for the health and welfare services', *PEP Broadsheet* 38, 534 (1972), pp. 2-3.

160. C. N. Thorpe, *The economics of family planning in South Australia* (thesis, Adelaide University, 1973).

161. Submission 612, AFFPAs.

162. Submission 148, FPA SA.

328. The Commission of Inquiry into Poverty also reported that it is the poor, particularly parents of large families, the young and single, the ethnic minorities and Aboriginals who make least use of contraceptive services.¹⁶³ Their poor access to contraceptive services arises from inability to pay for fares or supplies, difficulty in attending the service because of embarrassment, fatigue, absence of baby-sitters, or because they do not know the service exists. By definition, these are the people who have the least resources to cope with an unwanted pregnancy and who are most likely to rely on government welfare services. It is to these groups, therefore, that the expansion of contraceptive services must be directed and from whom the greatest benefit will flow.

The poor

329. The Poverty Commission noted that the poor fail to make adequate use of contraceptive services despite the fact that fees are often not charged.¹⁶⁴ A number of barriers were identified which restrict the practice of birth control and particularly affect the poor. These include ignorance, restrictive laws, government and community attitudes, cost barriers, lack of integration of services and behaviour patterns and attitudes.

330. A submission prepared by the Brotherhood of St Laurence for the Poverty Commission pointed out that poor families are not responding to the services as quickly as hoped. In their view:

... this highlights the need for intensive outreach and education programs aimed at breaking down popular myths and fallacies and presenting family planning as a promotion of family health.

They made the following comments on their own pilot family planning project:

Family planning services are an important, preventive measure in relation to the financial and emotional problems resulting from unplanned and unwanted children. The Brotherhood of St Laurence established the first comprehensive family planning clinic in Melbourne and finally completed this demonstration pilot project in December 1972. Although the clinic concentrated on assisting low income families, a subsequent research study suggested that the best response rate was amongst low to lower middle income groups who tended to be upwardly mobile. There tended to be a poorer response rate amongst those with social and emotional problems and those whose situation was static. If family planning is to be effective amongst those families who often have a strong, yet unrealistic, urge to have children, social casework services must be provided within the clinical setting.¹⁶⁵

An earlier report by the Rev. Peter Hollingworth on the family planning clinic pointed out the error in labelling children as unwanted and explained that some poor people may have a strong need to have children even though they may not be able to cope. The report warned that existing institutions may not meet the needs of the people in question and that the solution of contraception may not be acceptable.

331. Contraceptive services alone do not solve the social problems encountered by families in poverty. As the Rev. Peter Hollingworth pointed out, people may need some stability and confidence before being able to avail themselves of such services. Contraceptive services should be integrated with other services.

332. The Poverty Commission points out that unplanned children are a strain on resources, making people vulnerable to poverty. Many people might make more use of contraceptive services if their needs were given more consideration. It would help if these people were involved in planning programs.

163. *Social/medical aspects of poverty in Australia*, p. 147.

164. *ibid.*, p. 141.

165. Exhibit 231 (h).

Migrants

333. Migrants are over-represented in the lower socio-economic groups and generally represent an underprivileged group in society. There are few highly skilled and professional migrants in Australia. In addition to poverty, migrants also have social and cultural barriers to effective contraception. As we have seen there is a tendency, especially among southern Europeans, to use withdrawal—one of the less effective methods of contraception.

334. In the delivery of family planning services, communication is more than a matter of language. An understanding of cultural backgrounds is important as there is a wide gulf between Australian and southern European attitudes to sexual matters and contraception and childbirth.¹⁶⁶ For instance, many migrants refuse to let their wives use contraceptives in case of infidelity.¹⁶⁷ In Greece abortion is an accepted method of controlling family size. Contraception is seen as the husband's responsibility; withdrawal is the only method used in many groups.¹⁶⁸

335. Sister G. Brooking, education officer with the South Australian Family Planning Association, said that migrant women need access to oral and written family planning information in their own language and presented in the framework of their own cultural background.¹⁶⁹ Family planning clinics need the services of interpreters familiar with the social customs of migrants or, preferably, trained family planning workers of ethnic background. Doctors and nurses also need instruction on cultural background. Women from the ethnic communities themselves could be trained to give information¹⁷⁰ on what is often an alien idea. Judy McLean, director of the Family Planning Association of NSW, told us:

The ideal situation would be to train field workers or nurse practitioners who are ethnic people, come from that ethnic group themselves. They have the understanding of the cultural background. They know how fast they can move with ethnic women in talking about contraception, or a group of people, not necessarily women, because they have an understanding of the background of those people. There is also no language problem because it is their own ethnic group.¹⁷¹

336. We have already mentioned that occupational health services could be used to make contact with migrant women and provide information and services. There is also a need to involve migrants in planning contraceptive services to meet their needs and take account of cultural factors. A recent research report highlights some of the special needs of migrant men and women in contraceptive services.¹⁷² These include individual education and information for Greek men who must usually approve their wife's use of contraception, local clinics with community interpreters/educators and trained ethnic doctors.

The handicapped

337. Substantial groups in our society whose sexual and contraceptive needs are often neglected are the physically and mentally handicapped. The FPA has made some provision for the handicapped; we support their efforts and consider that there should be special provision made for contraceptive services to be available to the handicapped.

166. Submission 591, ACOSS; Evidence pp. 146–7, Miss V. Koutsounadis.

167. Interview reports, NSW, 1; Vic., 26.

168. Evidence, p. 2880, Prof. B. Hétzel; Caldwell & Ware, 'Australian attitudes towards abortion' in *Abortion: repeal or reform* (ANU, Centre for Continuing Education, Canberra, 1972) pp. 71, 90.

169. Evidence, p. 1435, Sr G. Brooking.

170. Evidence, p. 145, Miss V. Koutsounadis.

171. Evidence, p. 3070, J. McLean.

172. Hawker, 1977, pp. viii, ix.

Conclusion

338. The Poverty Commission recommended that priority be given to providing family planning services in ways which are more likely to make contact with poor people through community health centres, infant health and welfare centres, public hospitals, workplaces, mobile clinics in rural areas and Aboriginal medical services.¹⁷³ We support the recommendation. We also support their proposal to use trained family planning educators and counsellors to provide information and motivation to poor people.

339. To make adequate provision for people with special needs it is important in our view to develop a specialised service with flexibility and a wide range of choices. Such a service should take account of age, class, ethnic origin and marital status. The objective is to increase awareness and understanding of the benefits of contraception and of planning the number and spacing of children, and to plan services better able to meet the needs of people not now reached. This objective has the best chance of succeeding if community leaders and representatives of those special groups are directly involved in the planning of the services.

Cost of contraceptive services

340. The question whether contraceptive services should be free to the user needs to be considered in the context of the system of general health and medical services. Ideally, contraceptive services should be seen as part of preventive health programs and should be widely available without charge. The cost of the service may affect motivation. VD clinics are free; so are cancer smear clinics and baby health services. The cost of effective contraception is outweighed by the potential cost of unwanted births, abortions and large problem families.

341. Under the UK National Health Service contraceptive advice and supplies have been free of charge at family planning clinics since 1974. Since July 1976 general practitioners in the UK are providing free contraceptive services: prescriptions are exempt from charges.

342. Until the changes introduced in Australia in 1976, clinic patients received free family planning services and charges were bulk-billed. Under the present scheme everyone is covered by Medibank or by private insurance. Those with private insurance pay fees and claim reimbursement whether they go to a general practitioner or to a clinic. Those covered by Medibank standard may have to pay their general practitioner, but will generally be dealt with on a bulk-billing basis at family planning clinics. Some people who for reasons of privacy cannot use the family insurance cover of their husbands or parents are classified as 'unbillable' and pay no fees at clinics; the charges are bulk-billed to Medibank.

343. It is very important that people are not deterred from seeking contraceptive advice because they believe they cannot afford it. The present scheme gives some protection for those who can least afford to pay. It is not widely known, however, that people in the unbillable category need not pay. In any case the cost of service depends on whether clinics can maintain fees at the insurance refund rate. And, of course, people covered by private funds still have to pay for the service, even though the amount is recoverable.

344. We believe that the goal should be a free service. Extension of community health services, especially in areas of need, would help to bring this about. There are some steps which could be taken now to ensure that cost is not a deterrent. Family

173. *Social/medical aspects of poverty in Australia*, p. 160, rec. (4).

planning clinics should have sufficient funding to enable them to keep their fees at the refund rate and to waive fees in case of need; those seeking contraception should be aware of the 'unbillable' patient system and also aware that services may be without charge to those who cannot pay. We appreciate that a double standard is involved in giving concessions in respect of a service which should be a right.

Cost of contraceptive supplies

345. Another barrier to effective contraception for some people is the cost of filling prescriptions for contraceptives and of purchasing non-prescription items such as condoms. Subsidies have been given by the Commonwealth government for oral contraceptives through the pharmaceutical benefits scheme at a cost of \$16 323 000 in 1975-76. There are no subsidies for non-prescription items. The cost of contraceptives may affect the use of contraception and the choice of method. Table IV.19 shows costs per annum of various forms of contraception based on intercourse once, twice and four times per week. The prices are as quoted by FPA NSW in March 1977; prices from other suppliers may differ. The costs of sterilisation are shown for comparison.

Table IV.19 Annual cost of contraceptives

| | Each time of intercourse | Once per week | Twice per week | Four times per week |
|--|-----------------------------|------------------|-------------------|------------------------|
| | | \$ | \$ | \$ |
| The pill | n.a. | 10 | 10 | 10 |
| The IUD | n.a. | 5-10 | 5-10 | 5-10 |
| The diaphragm—add cost of jelly/foam | n.a. | 5 | 5 | 5 |
| Jellies, creams \$2.50 (per 25) | 10c | 5 | 10 | 21 |
| The condom \$2 per 12—add cost of jelly (above) or foam (below) | 16c | 9 | 17 | 35 |
| Foams \$4.50 (25) | 18c | 9 | 19 | 37 |
| Withdrawal | .. | .. | .. | .. |
| Periodic abstinence | .. | .. | .. | .. |

Source: FPA NSW, March 1977.

Table IV.20 Cost of sterilisation (March 1977)

| | Common fee | Benefit payable |
|----------------------|---------------|--------------------|
| | \$ | \$ |
| Female sterilisation | | |
| general | 96 | 91 |
| specialist | 120 | 115 |
| Anaesthetist fee | | |
| general | 27-33 | 23-28 |
| specialist | 35-40 | 30-35 |
| Male sterilisation | | |
| general | 57 | 52 |
| specialist | 71 | 66 |
| Anaesthetist fee | | |
| general | 20-50 | 17-45 |
| specialist | 24-50 | 20-85 |

Source: Medical benefits schedule, 1977.

The Poverty Commission recommended that all prescribed contraceptive goods be included on the pharmaceutical benefits list and that non-prescribed goods which are presently more freely available and cheaper should remain that way.¹⁷⁴ We support this recommendation. In our view, ways should be investigated of reducing the cost of contraception and of contraceptives.¹⁷⁵ Subsidies for good quality products may be one possible solution.

Planning for expansion

346. Contraceptive services are a specialised service which should, nevertheless, be offered as part of general health and medical services both for the economies which this affords and for the benefit of the patient. It is preferable for the patient who is presenting with a request for a prescription for oral contraceptives and a complaint about a vaginal infection, for example, if both matters can be dealt with by one person in one place. This includes any necessary tests. It is even more convenient to the patient if other health problems may also be dealt with at the one location and it may be easier for some people to approach a more broadly based service.

347. As we have seen, the main service providers at present are general practitioners and family planning and other clinic services. Both are capable of providing a wide range of medical and health services. A number of medical practitioners continue to see clinic services as suitable only for the needs of the socially or economically disadvantaged and as being, in some ways, a threat to private practice.¹⁷⁶ We do not consider that this attitude is justified. Many women from all social levels will prefer clinic services; single women especially may prefer the anonymity offered. Nevertheless, many others will continue to consult their general practitioner. A recent research project in Sydney found that knowledge of services is much higher than use of or satisfaction with the service; satisfaction with general practitioners is low especially among single Australians because of communication difficulties. Chemists were considered difficult to talk to and nurses were not considered experienced enough. The FPA was widely known but little used because of its inaccessibility. It was little used by Greeks and Yugoslavs. Most women in the survey wanted local clinics or home services.¹⁷⁷ We consider that there should be a variety of services and that steps should be taken to improve the quality and scope of existing services. People should have a choice of services of high standard.

General practitioners

348. The general practitioner is the preferred source of contraceptive services for many, and has an important and continuing role. The main disadvantage has been the lack of specific training and the discouraging attitude of some GPs. To improve the quality of GP services there needs to be undergraduate and post-graduate training and also refresher courses for GPs.

Clinic services

349. There are advantages in the provision of comprehensive clinic services. Medical services obtained from a clinic should not be seen as inferior to private general practitioner services, nor should certain types of client be expected to support private medicine. Clinic sources of contraception should not be confined to a narrow range of services delivered to some difficult-to-define group of 'poor' people. The clinic services are the preferred choice for people from all socio-economic groups; indeed they are well supported by the middle class.

174. *ibid.*, p. 161, rec. (14).

175. Submission 193, David Morrow.

176. Submissions C1263, confidential; 1101, AMA; 612, AFFPAs.

177. Hawker & Banfield, 1976, pp. 5-6.

350. In our view the clinic services offer the best opportunities for expansion to meet the needs of those groups not presently availing themselves of contraceptive services. They should plan to reach groups not now reached and to provide services accessible to and acceptable to those groups.

351. The choice for the government is whether to continue to fund FPAs to expand and provide more and more local clinic services, or whether to encourage State departments to take over local clinics and administer them in conjunction with the community health centres now being established. The advantage of the latter course is that it would avoid the difficulties which a voluntary organisation would face in setting up a broad network of services, and it would avoid the duplication of departmental structures which such a network would entail. It would also open the way for integrating family planning services within the community health centres.

352. If the latter course were adopted, the FPAs could be funded to provide a number of more specialised clinic services and to continue with their training and community education functions, which would be complementary to community health clinics. This would parallel developments in the UK; since family planning became part of the National Health Service most family planning clinics have been transferred to the local authorities. The FPA retains an educational and training role and maintains specialised clinics for this purpose.

Policies for expansion of services

353. Changes in the current approach of some State governments would be needed. Some State Health Departments are still reluctant to assume a role in contraceptive services. In 1974 the NSW Health Commission turned down an offer by the FPA NSW to hand over many of its suburban clinics and to incorporate them into community health services. We are concerned that many poor people, migrants, Aborigines and people living in remote areas have no effective access to services vital to their physical and mental health. The Commission of Inquiry into Poverty noted:

The reluctance of both State and Federal governments to become too directly involved in providing family planning services or assisting voluntary agencies has led to the development of a service network comprising mostly private agencies. This network has been unable to meet community family planning needs.¹⁷⁸

We agree that family planning services should be provided as part of a nationally organised health care network in which co-ordinated preventive and curative care is directed towards each individual and family.

354. We consider that the government should take the initiative and declare that contraceptive services are a governmental responsibility as part of preventive medicine. This would open the way to the development of a comprehensive Commonwealth and State policy in this area. The government should take initiatives to ensure the extension of services by State or voluntary agencies and provide funding and subsidies necessary to achieve this end.

355. In our view, these policy goals should be achieved progressively by:

- (a) establishing a national network of contraceptive clinics in community health centres run by State Health Departments;
- (b) rationalising the funding of voluntary organisations such as Family Planning Associations, and ultimately providing that each FPA becomes a specialist resource organisation for State-run clinics.

178. *Social/medical aspects of poverty in Australia*, p. 150.

356. The number of community health centres needs to be increased and a contraceptive clinic service should be established by State Health Departments in each community health centre. The Commonwealth Department of Health should establish standards for the conduct of these clinics, in consultation with Family Planning Associations, and funds should be set aside for a nation-wide campaign advertising the services and their location.

357. Until the above action is taken by State Departments, the FPAs should be funded to expand their services. We were informed that present levels of funding are to be maintained. In real terms, of course, this means less money than last year. To provide the services needed, more funds should be made available; money spent on contraceptive programs may lead to money saved on other programs in the long term. Adequate funding is needed to ensure the provision of domiciliary personnel, new clinics and national advertising campaigns. Without such measures neither the poor, nor the Aborigines, nor the migrants, nor young people, nor the isolated will be reached by contraceptive services.

358. An expansion of contraceptive services, however achieved, will require further training programs for medical and paramedical personnel. Some FPAs already train doctors and nurses for State Health Departments. Since 1975 a co-ordinating committee has been set up in each State to carry out an education program in family planning for medical personnel. Representation includes the RACGP, the RCOG, the Medical Post-graduate Committees, Family Planning Associations, the Catholic Social Welfare Commission, the Family Medicine Program, the Commonwealth Department of Health and medical students. Programs are under way in most States. If contraceptive services are to be expanded it is essential that funding be provided to support the extension of training programs by FPAs and other bodies.

359. There is also a need to co-ordinate existing services to ensure that every community has the best possible cover from a range of services. To bring this about a national advisory committee should be appointed to advise on policies for co-ordinating, integrating and expanding services. Representatives of medical, nursing and social work professions, voluntary organisations and consumer groups should be included. Information about services in a particular area should be published and disseminated broadly. The committee should also advise on the desirability of establishing a national training centre.

360. More needs to be done to provide for referrals to FPA and other contraceptive services from other agencies which have direct contact with people who may need such services. These include social workers and pharmacists, doctors, hospitals and welfare agencies. Their professional training should enable them to be aware of the need for contraceptive services and to give advice to those who need it or refer them to counselling services.

Getting the message across

Introduction

361. We have considered what action can be taken to motivate people to take responsible decisions about their sexual behaviour, to help people to limit the number of children to those they can afford and cope with and to reduce the number of unwanted pregnancies and unwanted children.

362. The main elements in the program are education, information, service provision and motivation. They are closely linked to each other, since education is part of motivation and service providers should be active in both education and motivation.

This section gives special emphasis to motivation through media advertising; education and service provision are considered elsewhere in more detail.

Education and information

363. Evidence available to us suggests that, for many people, ignorance, misinformation, inaccessibility and mismanagement are major factors affecting their ability to use contraception effectively. Many inhibitions and confusions could be lessened by the provision of comprehensive information about sexuality, intercourse, anatomy, physiology, reproduction and contraception. The illuminating quality of good information has often been overlooked.

364. Earlier parts of this report have discussed sex education programs and the importance of including basic information within a framework of education for human relationships and personal development. Information about conception, contraception and contraceptive services should be a part of this education, and it should be provided at schools and tertiary institutions. The effectiveness of this kind of education depends to a great extent upon social attitudes and on the willingness and ability of people to discuss freely and frankly the issues involved.

365. An individual is expected to know how to keep clean and healthy. Basic hygiene, diet and safety are automatically taught, so, equally, contraception should be taught in recognition of the fact that everyone is a sexual being. Acquiring knowledge about contraception gradually as a part of growing up is the most satisfactory way of learning about it. Education programs should do more than impart information: they should aim to develop within the individual the ability to face up to issues, to make responsible decisions and to accept responsibility for the consequences of those decisions.

366. Information is an essential aspect of responsible decision making. Education programs should include information about community services. The French Project on Women recently recommended that a booklet be prepared for young people leaving school including information about sex and information centres.¹⁷⁹ We have commended the NSW pamphlet 'Single, pregnant, what shall I do?' at Annexe IV.I. Equal time and effort should be put into pamphlets or booklets designed for young people and containing basic information about sexuality, conception and contraception and about relevant services such as family planning clinics and VD clinics.

367. Community leaders could play an important part in increasing awareness of contraceptive issues. The co-operation of employers, trade unions and voluntary agencies would assist in the dissemination of information and in the provision of special services, such as occupational health services.

Service provision

368. The outreach program of contraceptive services should include public education and motivation as well as informing people about services. The services and education programs should be flexible and use a diversity of means, such as domiciliary services and workplace schemes.

369. Services should be made visible to people if they are to use them. Discreet posters in baby health clinics and small signs announcing 'family planning' are neither eye catching nor memorable. Large signs are required, clearly stating the name of the

179. Secrétariat d'État à la Condition Féminine, *Projet pour les femmes 1976-1981* (Édité par le service d'information et de diffusion), pp. 57-9.

clinic and its purpose. A new and recognisable 'logo' would assist and also an indication that the clinic or centre is for all people who want to control their fertility, men and women, married and unmarried. We think that the term 'family planning' may be discouraging to young people and possibly misunderstood by others, though it is a well-established term.

370. New kinds of services with street-front locations and signs should be made highly visible for specific groups of people who find the FPA-type clinics difficult to use. Such services as teenage 'action centres', drop-in centres and clinics for Aborigines, migrants and the middle-aged may be placed clearly in shop fronts on busy streets where those who are shy, without easy access to transport, afraid of travelling to unknown suburbs or without a telephone can see the clinic. Such services should also be supported by advertising.

371. Contraceptive services provided by pharmacists should in our view be made more visible. There is no reason why signs and posters advertising the contraceptive service of pharmacists cannot be clearly displayed in chemist shops. A simply worded notice could announce 'Contraceptive items sold here'. Pharmacists who do not stock contraceptive items should be encouraged to indicate this in a similar fashion. Contraceptive goods should be displayed on open shelves. It is also our view that condoms and other non-prescription items should be widely and openly available through a large number of retail outlets. It should be possible to use vending machines for condoms.

372. The medical profession should be encouraged to undertake specific instruction on contraception or at least to refer their patients to other specialised services. Doctors waiting rooms could carry educational literature and information about local services.

373. Similar literature and information should be widely distributed through the community, eg. through pharmacies, social workers, post offices, infant welfare centres, community centres and public libraries. Health Departments have a responsibility to ensure the dissemination of information in several languages.

Motivation

374. There are significant numbers who know about contraception but who nevertheless do not use contraception. For them programs need to have a motivational approach. This implies some knowledge of what factors influence decision making and behaviour. We need to know more about the influence of relations, friends, neighbours and workmates in this process. The influence of a woman's husband or partner may also be important. If so, motivational programs should take into account the male role and attitude.

375. A recent research project in Sydney looked at some of these factors and concluded that the message should be linked with something that is important to the woman concerned or be presented by someone whose advice is respected.¹⁸⁰ The survey noted the sources of information for various groups and pointed out that, as many of the women were not organisation joiners, education should be through informal communication channels and the mass media.¹⁸¹

376. A follow-up survey examined social networks and found that in some ethnic communities there were strong networks and religious groups; the conclusion was that opinion leaders in these networks could help to influence and motivate other members.¹⁸²

180. Hawker & Banfield, 1976, p. 7.

181. *ibid.*, pp. 5, 6.

182. Hawker, 1977, p. vii.

Media

377. Media advertising is another way of informing people about services: where they are and what they provide. The media also have a potentially more important role in relaying to the uninformed messages which could affect their motivation to use services. These messages could be used:

- (a) to persuade people that a service will benefit them, that it is responsive to their needs and that it is an acceptable service;
- (b) to explain about the different methods of contraception, their effectiveness, safety and side effects;
- (c) to promote responsible decisions about sexual behaviour.

378. In Australia national advertising campaigns have been sponsored by the government to encourage people not to smoke and not to drink and drive, but the more fundamental issue of contraception has never received government sponsorship on a nation-wide basis.

Advertising campaigns by FPAs

379. The only advertising campaigns undertaken so far have been those of Family Planning Associations. Their campaigns have been of short duration and coverage due to lack of funds. They have used posters, newspaper and magazine advertisements, radio commercials, editorial comment and articles. Radio has been used least because of cost, although this may be a more effective medium than the others; television has been out of the reach of FPAs. The dominant themes of the advertisements are knowledge, responsibility and frequently a warning.

Victoria

380. The FPA in Victoria used posters on buses and trains with the following messages:

- (a) Stop and think. If you decide it's your responsibility to be informed about contraception, both of you, come and visit us . . .
- (b) Approach with caution. You know all the methods of contraception, but do you? If you would like to be fully informed . . .
- (c) It's time to go. Go ahead and do all those things you've been planning to while your family has been growing up.
- (d) Are you in the dark? We can open your eyes to all the facts about contraception.

Australian Capital Territory

381. The FPA in the ACT used these messages on some recent posters:

- (a) 'Bob, I'm late.'
'I know, twenty minutes.'
'No, Bob. It's about two weeks.'
To have sex without children, you have to take precautions. Otherwise, well, you know the consequences . . .
- (b) 'But darling, there are lots of ways you can stop yourself falling pregnant.'
'Oh mum, now you tell me.'
Contraceptive advice—it's a responsibility lots of parents refuse to face up to.
- (c) Two's company.
Three can be a crowd.
One and one makes two. Take away contraception and you've got three . . .

- (d) 'If a woman can't look after herself, that's her problem.'
It may be unspoken. But it's an attitude many guys have.
- (e) 'I'll never forget the first time.'
With contraception, you shouldn't have to learn from experience.
First time unlucky means a sudden shock—and weeks of worrying about what to do.

382. The campaign consisted of radio advertisements and newspaper advertisements with a television commercial to explain the case for contraception; the theme was 'How to live with love'. The Health Department paid for the campaign (which was estimated to cost \$13 000). The program ceased early when funding was stopped.¹⁸³

Western Australia

383. In Western Australia, the FPA ran a series of taped messages on radio with the common theme song: 'There's got to be a morning after'. The message was built up progressively:

- The Family Planning Association is not just for planning families; birth control is something we should all learn more about.
- The FPA doesn't expect you to do the impossible; it can help to prevent unwanted pregnancy. If you have questions about sex and birth control, phone . . .
- Don't imagine you are the first to need advice about sex and birth control.
- Would you like to talk about sex problems or birth control? Talk to us . . . there's *no* 'You're a little young to be calling in here dear'.

Other States

384. The FPA NSW ran a short-lived poster concerning an innocent Alice whose departure from 'wonderland' was precipitated by an unplanned pregnancy. A TV campaign in South Australia brought a big increase in attendance.¹⁸⁴ Other means used were bus posters and advertisements in drive-in movies.

Evaluation

385. Some of these messages provide negative motivations to contraception. They threaten dire consequences (an unwanted pregnancy) and by the absence of positive statements support the notion of sexual intercourse as an undesirable activity except in specific circumstances. One submission noted:

. . . the punitive pre-marital postulate, mainly directed at . . . girls, that if sex is experimented with before marriage, the outcome will be unwanted pregnancy involving severe social repercussions for herself and the whole family. The result of such an attitude must be the conclusion that sex is a punishable activity.¹⁸⁵

386. The Perth program seems to be more positive in its approach. The desire to placate potential opposition and avoid censorship may explain the gloomy implications of the advertising messages. Although they may increase attendance at clinics temporarily, there is no evidence that they effectively encourage people to change their behaviour. Rewards rather than threats are usually more effective for this purpose.

Overseas experience in advertising

387. Overseas studies suggest that there are limitations on the impact of media advertising about contraception. In 1972 the English FPA ran a controlled experiment

183. Evidence, p. 3071, J. McLean.

184. Submission 143, SA Medical Womens Society.

185. Submission 105, Dr Grahame Dudgeon.

in two towns, saturating them with information about birth control and with readily available family planning services. The number of women using medical means of birth control increased but no aspect of the campaign could be isolated. Births fell in one place the next year and increased in the other. The response from mothers of large families and those in greatest need was disappointing. The Health Education Council decided after a TV campaign that television is best used in support of a press campaign.¹⁸⁶

388. In the United States a government-sponsored, 6-month, \$330 000 multimedia campaign was undertaken to test whether advertising could increase effective contraceptive action among the sexually active.¹⁸⁷ Although attendance figures rose this was temporary and mainly due to forward borrowing of those who would have come. It was concluded that mass advertising was not an effective means of recruiting, though it was thought that different messages might have had a more important effect on behaviour. The theme of the campaign was 'Stop the stork'.

More effective campaigns?

389. In a report entitled 'Twenty-five communication obstacles to family planning progress', Donald Bogue has claimed that well-designed mass media communications can overcome each of twenty-five obstacles to the control of fertility, including these:

- (a) Fears of permanent damage to health from prolonged use of pill, IUD or other contraceptives.
- (b) Fears of the short-term side effects of the pill and IUD.
- (c) Irrational fears of the vasectomy method.
- (d) Inadequate communication between husbands and wives about ideal family size, spacing, contraceptive methods and whether to practise family planning.
- (e) Lack of awareness of family planning services.
- (f) Tolerance of the low status of women and weak support of the movement for women's rights.
- (g) Contraceptive fatigue, carelessness and negligence.
- (h) Fatalism and control of one's own career.
- (i) Infidelity (fear of spouse being unfaithful if modern methods of contraception are used).
- (j) Withholding family planning information from sexually active teenagers and other mature unmarried persons.
- (k) Under-exploitation of the immediate and intermediate advantages and benefits of family planning (e.g. economic benefits, time for relationships with existing members of the family).¹⁸⁸

390. In Australia some of these obstacles are more prevalent than others. For example, fear of side effects, inadequate communication, lack of awareness of family planning services, tolerance of the low status of women and the withholding of information from sexually active teenagers are obstacles particularly pertinent to Australia.

186. Information from the FPA, London; campaigns have been reported: Isobel Allan, Birth control in Runcorn & Coalville: a study of the FPA campaign (PEP); Health Education Council, Report on the experimental television campaign on family planning in Yorkshire.

187. J. R. Udry, L. T. Clark, C. L. Chase and M. Levy, 'Can mass media advertising increase contraceptive use?', *Family Planning Perspectives* 4, 3 (1972).

188. D. Bogue, 'Twenty-five communication obstacles to family planning progress', *Media Monograph Series*, no. 2 (Communication Laboratory, Community and Family Study Centre, University of Chicago, 1975).

391. In a companion monograph Remsburg et al. provide examples of 'spot announcements' for use on radio and television. Each announcement is geared to overcoming a particular obstacle. Some examples follow (for others see Annexe IV.G).

Obstacle 10

Lack of awareness of family planning services

This is an announcement from your Family Planning Unit.

We want you to know that a family planning clinic was recently opened at 80 Marabell Road in San Fernando. This brings to five the number of clinics operating in the county of St Patrick. Their locations are . . .

Obstacle 24

Withholding family planning information from sexually active teenagers and other mature unmarried persons.

Do you have a teenage son or daughter? What do you think, is he or she sexually active? Let me answer for you. Whatever you may want to think, the answer is probably . . . yes. That's what I said. Yes. With today's improved diets, with today's improved education, youngsters are sexually mature several years earlier than in our time. Times have changed and responsible parents will change with them. Talk frankly and openly with your youngster about sex. Don't pry, just talk, and tell him or her that the family planning centre is the best place to learn all about preventing unwanted pregnancies. One thing that hasn't changed down through time: the worst way to get married is to have to.¹⁸⁹

392. With regard to young people, we commend a new poster used by the FPA NSW to advertise its Hornsby clinic. Two teenagers are shown in jeans and T-shirts. The boy says, 'How come you know so much?' and the girl replies, 'Because I've been to an FPA centre and had a chat about sex and contraception'.

393. The American papers suggest that properly designed advertising could be part of a general campaign to raise the level of awareness and motivation. Clearly there is still much to do in evaluating programs for Australians.

Views about advertising

394. Some submissions were opposed to any suggestion of advertising contraceptive services in the media. The ACT campaign was the subject of criticism by the ACT Right to Life Association on the ground that it was pitched at 'recreational sex'. They were also concerned that the 'Catholic Family Planning Association' had not been funded.¹⁹⁰

395. The Knights of the Southern Cross also opposed advertising:

However, when we come to the question of *advertising of contraceptives* we have to face the fact that we have now moved on to the public stage. Our utterances now have wide dissemination. There is no way of preventing them coming to the knowledge of a large number of adolescents whose parents may resent and reject the contraceptive philosophy and its implied attitudes. Such parents have the right to have their wishes respected. The advertising of contraceptives should therefore be a restricted type of advertising in the type of journal carrying the message to health personnel in the given field. There is no place whatsoever for the widespread advertising in ordinary newspapers or ordinary weekly magazines of this type of agent.¹⁹¹

They also opposed the provision of condom vending machines in tertiary institutions.

189. B. Remberg, D. Price, J. Towbridge & G. Daffin (eds) 'Radio and television spot announcements for family planning worldwide', *Media Monograph Series*, no. 3 (1975), pp. 27, 81, 94, 95, 147.

190. Submission 197, ACT Right to Life Association.

191. Submission 211, Knights of the Southern Cross.

396. Others felt that contraceptives should be freely available and that one way of achieving this would be to advertise where they may be obtained.¹⁹² One view was that young people should be protected from unwanted pregnancy.¹⁹³ Another was that the censorship is appalling while alcohol and cigarettes are advertised widely.¹⁹⁴ The view of the Queensland branch of Zero Population Growth was that:

Given comprehensive sex education without censorship and repression, advertising of contraceptives and their free availability, and open discussion of sexual matters, it is suggested that the problems outlined are able to be solved . . . Ignorance creates confusion, unhappiness and resentment. It can also give rise to rebellion against those who encourage ignorance.¹⁹⁵

Some called for extensive advertising of contraceptive services to avoid the cycle of deprivation and to improve the quality of life.¹⁹⁶

Conclusions

397. The right to information is not modified by marital status or age. Ignorance and misinformation do not deter sexual behaviour but may occasion unwanted conceptions. In our view young people are not deterred from sexual behaviour by the absence of contraception even though they may worry about pregnancy. We do not believe that advertising of contraceptive services promotes promiscuity.

398. We do not support proposals to restrict the advertising of family planning services or contraceptives. The absence of such advertising may have negative implications, by implying that there is something 'wrong' in it.

399. The question remains whether media advertising can be effective in informing and motivating people to make use of contraceptive services when they would not otherwise do so. In particular, can it be used to reach those at highest risk?

400. Advertising has its limitations; material planned for an English-speaking community will probably have little impact on the non-English-speaking migrant community. To reach them more informal channels are needed. Ethnic radio and newspapers could be used. Nevertheless it is our view that the media could and should play a more positive role in shaping community attitudes and in providing community services. The promotion of effective contraception by educational and motivational programs is one way of playing this role. A comprehensive program to motivate effective contraception should include advertising. Experimental programs are needed to allow some evaluation of the cost and effort involved. Australian and overseas experience suggests that too little is known.

401. We consider that, as part of a comprehensive contraceptive service to everyone in the community, the government should initiate and support nation-wide and local advertising campaigns to encourage the use of contraceptive services. These could be undertaken as part of total public health education programs; alternatively they could be directed toward special target groups of people with special need. In addition, funds should be made available to each FPA or other voluntary organisation providing contraceptive services to advertise its locality and services. Increased advertising should lead to increased demand for services, at least in the short term, and this should be considered in planning programs.

192. Submissions 208, J. W. Gilmour; 454, Mrs G. Pack; 694, Mr & Mrs C. F. Johnson; 905, Sr Patricia Hewitt, FPA Tasmania.

193. Submission 204, Mrs J. Fullard.

194. Submission 193, David Morrow.

195. Submission 1004, ZPG (Australia), Qld branch.

196. Submissions 143, SA Medical Womens Society; 936, Miss G. Graetz; 73, Jo Wainer.

402. Advertising programs are only one element in the total program. Advertising alone cannot overcome inadequate services or compensate for a poor image. To develop in people the capacity to take responsible decisions about their sexuality a comprehensive program is needed, comprising:

- education and information for people of all ages
- ready access by all people to services and supplies suitable to their needs
- motivational programs to develop the ability to make responsible decisions

Contraception and the law

Introduction

403. To make fertility control effective for everyone in the community, services and supplies should be available at suitable times and places and people should know about them. There are, however, legal restrictions which are said to impede unnecessarily access to contraceptive services or supplies. These restrictions can also affect motivation by implying disapproval of the activity in question.

404. The importance of removing legal barriers to contraceptive services and supplies was recognised by the Poverty Commission. Its third main report recommended that:

Representatives from the medical, legal and government fields consider all restrictive laws relating to family planning and their effects, with the intention of making a comprehensive family planning service available to all people.¹⁹⁷

At present laws relating to contraceptive services and supplies are mainly negative. There is a need for positive laws to promote the quality of contraceptives and to protect the users of services.

Advertising of contraceptive supplies and services

405. The Poverty Commission commented as follows:

Legislative restrictions on advertising in most States prohibit the display of contraceptives and public dissemination of information on birth control methods. In South Australia and Western Australia there are no legal restrictions, but a barrier still exists because major newspapers, under a 'voluntary code', do not publish any such advertising. Advertising and sales laws have long been and still are a topic of debate in Victoria but some recent changes have been made which enable advertising of contraceptives on radio and in trams. A series of radio, television and newspaper advertisements was used in mid 1975 in the Australian Capital Territory by the FPA but funds have not been available since. Although the advertisements were available to other State FPAs none have used them. Cost and varying State laws are the main restrictions on such a campaign.¹⁹⁸

406. Taking Australia as a whole, the position is confused and confusing.¹⁹⁹ There is not always a clear distinction drawn between the advertising of services and the advertising of products. In Tasmania, until 1976, contraceptives could not be advertised at all except in medical and pharmaceutical journals.²⁰⁰ In Victoria permission has to be obtained for advertising contraceptives. In New South Wales the position is uncertain. In Queensland laws relating to obscene and indecent material may prevent advertising.²⁰¹ In South Australia and Western Australia there are no special restrictions.

197. *Social/medical aspects of poverty in Australia*.

198. *ibid.*, p. 148.

199. P. Whalley, Dept of Demography, ANU, Laws relating to contraceptives in Australia (seminar paper, presented August 1972); for further information see H. Finlay and T. Gleeson-Sihombing, *Family planning and law* (FPA, Sydney, in press: revised edition of Finlay & Glasbeek).

200. *Police Offences (Contraceptives) Act 1941*: this Act was repealed in 1976.

201. *Vagrants, Gaming and other Offences Act 1902-1974*.

407. In the ACT and the Northern Territory restrictions on the advertising of contraceptives were amended in 1973, though it is still an offence to advertise any instrument or appliance for 'influencing the course of pregnancy'.²⁰² There is also a prohibition on companies advertising the services of medical employees; this could hinder the Family Planning Association, which is incorporated in the ACT.²⁰³

408. The advertising of services and products on radio and TV is another doubtful area. The *Broadcasting and Television Act* 1942–1976 prohibits the broadcasting of matter which is 'blasphemous, indecent or obscene', but these are not defined.²⁰⁴ A circular from the Broadcasting Control Board in 1975 relaxed restrictions on advertising intimate products. The program standards have been under review. In fact some FPAs have broadcast advertisements about their services.

409. Where advertising is permitted by law, those in control of press, radio, TV and/or other advertising outlets (public transport etc.) may impose unofficial censorship. There is also a problem for FPAs and others to find money to advertise their services. Lack of finance may be a more potent obstacle to advertising than the law itself, though legal uncertainty can easily be blamed by those seeking to preclude advertising.

410. In this confusing situation several of our submissions asked for legal clarification to enable advertising of contraceptives and contraceptive services.²⁰⁵ It was proposed that the Australian Parliament should legislate for freedom of advertising of contraceptives and that more money should be available for advertising and education films.²⁰⁶

411. In Tasmania the *Police Offences (Contraceptives) Act* 1941 prevented advertising of contraceptives except in medical and pharmaceutical journals. The Select Committee on Therapeutic Goods, Health Foods and Cosmetics found in 1975 that:

There is conflict between the advice of the NH & MRC to the States to make family planning advice more generally available and the provision of the Act which prevents the dissemination of any material which would indicate that such services are available.²⁰⁷

The Committee's view was that there should not be unreasonable restriction on the dissemination of knowledge about the availability or use of contraceptives. They concluded that there was a need to regulate advertising and provide standards, and recommended complementary Commonwealth and State legislation. New legislation was introduced in 1976 and the above Act was repealed.²⁰⁸

412. In 1974 the Queensland Commission on the Status of Women recommended that the advertising of contraceptives be referred to the Law Reform Commission for clarification. In their view there should be control but no blanket prohibition on the advertising and sale of contraceptives.²⁰⁹ Recent changes in NSW law may affect the advertising and sale of contraceptives. The Indecent Articles and Classified Publications Act of 1975, although not mentioning the term 'contraceptive', prohibits under section 10 the advertising of products which are:

. . . primarily concerned with, or used or intended to be used in connection with sexual behaviour.

202. Pharmacy Ordinance, section 46.

203. *Medical Practitioners Ordinance* 1930–1963, section 36 (2), section 91.

204. Section 118; see H. Finlay and S. Glasbeek, *Family planning and the law in Australia*, part B (FPA, Sydney, 1974) p. 93.

205. Submissions 556, Cole & Beighton; 148, FPA SA; 208, J. W. Gilmour; Evidence, p. 2568, Geraldine Pack; p. 3068, J. McLean.

206. Submission 148, FPA SA: Evidence pp. 1439 ff, Sr G. Brooking.

207. Report, 20 May 1975, in Submission 905, FPA Tas.

208. Therapeutic Goods and Substances Act, No. 1 of 1976 (Tas.); Police Offences (Contraceptives) (Repeal) Act, No. 36 of 1976 (Tas.).

209. *Report of the Commission of Inquiry into the Status of Women in Queensland* (1974) pp. 12, 31.

The regulations go on to allow for the exception of certain organisations, such as family planning, from the prohibitions contained in this section. Certain literature, not being brief advertisements on contraceptives or family planning matters, may be affected by other sections of the legislation, such as sections 12 or 17, relating to the classification of publications and the sale and display of such classified publications.²¹⁰ It is difficult to say what effect the new legislation has on the extent and type of advertising concerning contraception in NSW—the need to apply for permission to advertise may continue the inhibitions.

413. In Victoria the attempt to clear up legal uncertainties has led to detailed legislation about advertising and sale of contraceptives which appears to us to be over-restrictive. The *Health (Contraceptives) Act 1974* and the *Health (Contraceptives) Regulations 1975* deal with the registration, advertising, sale and exhibition of contraceptives. These are broadly defined in section 270B (1):

‘Contraceptive’ means a contrivance, device, substance or appliance for securing or reputed to secure by the use before, during or after sexual intercourse between human beings that such intercourse may take place without resulting in or with less likelihood of resulting in conception and includes any drug or other chemical or biological substance which is or is reputed to be effective or of use for that purpose but does not include a substance or a mixture or compound of substances or a drug—

- (a) that is extemporaneously dispensed or prepared for a specific and individual case; or
- (b) that [conforms to a standard formula and is sold under the name ascribed to it.]

Wholesale dealers may apply for contraceptives to be registered. There are restrictions on the words appearing on packaging. The sale of unregistered contraceptives and the display of contraceptives are offences except in the case of a pharmacist, medical practitioner or approved family planning clinic. Pharmacists may not offer or expose contraceptives for sale on view to persons in the public street. All advertisements must be approved by the Chief Health Officer.

414. In August 1975 the Melbourne Tramways Board lifted its earlier ban on advertisements and the State government made some funds available for FPA posters to appear.²¹¹

415. WEL submitted that the legislation falls short of what is desirable and that there should be no legislation about the sale of contraceptives other than that required to regulate dangerous drugs. In their view the display, advertising and promotion of contraceptives should be subject only to the same safeguards as other goods, namely that they should not be false and misleading. They proposed:

- (a) that there is no need for individual advertisements to be approved;
- (b) that if contraceptives are to be registered this should be only to ensure compliance with guidelines as to safety, reliability and effectiveness;
- (c) that packaging should be required to state the effectiveness of the product;
- (d) that if a contraceptive is registered its sale should not be restricted to an approved outlet.²¹²

416. The main justification advanced for restricting the advertising of contraceptive services or products is that it might in some way offend public taste. This objection could apply to advertising of any product or service. We do not consider that the advertising of contraceptive products or services has anything inherently distasteful or offensive which calls for blanket restrictions. Contraceptives are part of the daily lives

210. For further details see Finlay & Gleeson-Sihombing, pp. 2–5.

211. The Melbourne Age, 7 August 1975.

212. Submission 210, WEL, Victoria.

of many thousands of people. People are entitled to be informed of services which are available to them and which are important to their health and welfare. The restriction of advertising may itself carry a negative impression that the matter banned is in some way wrong. Advertising can inform. It can also affect attitudes. The potential of advertising to influence attitudes is, of course, one reason why there is agitation to restrict advertising of tobacco and alcohol. It seems to us that this potential could also be used to raise the level of community understanding and acceptance of contraception.

417. For all these reasons our view is that there should be no legislation restricting the advertising of contraceptives or of contraceptive services. This form of advertising would remain subject to the general law; it should be made clear that the fact that advertising deals with contraceptive products or services would not of itself offend against any such law.

418. In our view the media, in particular newspapers, TV and radio, should examine their policy on advertising contraception. The acceptance of such advertisements may play an important part in gaining acceptance for contraception and in overcoming reticence, fear and ignorance.

Distribution, display and sale

Prescription items

419. Oral contraceptives require a prescription; this adds to the cost and means that it is necessary to see the doctor. IUDs must be inserted by a doctor and diaphragms should be fitted by a doctor though they can be bought without prescription if the size is known. Oral contraceptives are dealt with under the Poisons Acts and Ordinances²¹³, which restrict their sale to pharmacists. In some States, and in the ACT and Northern Territory, medical practitioners may dispense restricted substances but may not necessarily be able to charge for them. Other contraceptives, such as IUDs and diaphragms, may come within laws specifically restricting the sale of contraceptives.

420. In Tasmania there were restrictions which prevented doctors from supplying contraceptive devices such as IUDs and family planning clinics from supplying any contraceptives. The Select Committee recommended:

That medical practitioners be permitted to supply and charge for any contraceptive article or device they may prescribe.

Under the 1976 legislation, referred to above, family planning clinics are able to sell contraceptives to patients.

421. We were told that some chemists do not in fact supply contraceptives. In some country towns there is no source of supply and we were told of cases where people had to go elsewhere, or visit several chemists. Family planning clinics supply contraceptives (except in Tasmania) but are not in many locations and are open only at certain times.

422. Pharmacists should be encouraged to make contraceptives available and should be permitted and encouraged to display a sign to indicate whether or not they do so. We do not think they should be required by law to sell contraceptives, but the failure of some to do so makes it important to ensure that other outlets are available, including family planning clinics and doctors.

213. e.g. NSW Poisons Act, 1966–1974, Victoria *Poisons Act* 1962 and Regulations; for the laws in each State see Finlay & Gleeson-Sihombing.

Non-prescription items

423. The main non-prescription contraceptives are condoms and spermicides such as foams, pastes, creams or jellies. The legal position varies from State to State. In general, condoms can be bought from pharmacists and family planning clinics and, in some places, from barbers.

424. In Tasmania contraceptives can only be sold by pharmacists. In Victoria sale of contraceptives is restricted to pharmacists, medical practitioners, family planning clinics and approved places.²¹⁴ In Western Australia contraceptives may not be sold in a shop or other public place; there is an exception for a registered pharmacist.²¹⁵

425. All the above restrictions affect sales by vending machine. In Queensland contraceptives may not be supplied by vending machine unless the Director of Health permits.²¹⁶

426. In NSW there are restrictions on businesses selling sex articles (with an exemption for family planning clinics) and a prohibition on sale by vending machine of substances which inhibit or modify physiological processes in man.²¹⁷ We are informed that, in NSW, condoms are sold by vending machine in places such as hotels and clubs and at least one university students union.

427. There are no restrictions on the sale of non-prescription contraceptives in the ACT. In the Northern Territory only pharmacists may sell contraceptives; they may use vending machines.²¹⁸

428. We received a number of submissions proposing that condoms should be far more widely available than at present, e.g. in places such as supermarkets, milk bars, from vending machines.²¹⁹ Condoms are available without the need to visit a doctor or clinic and are reliable when correctly used. When the woman uses foam the effectiveness is very high. They are useful in intermittent or casual relationships and also provide some protection against VD. Among the reasons put forward for extending sale outlets were that many young men are reluctant to ask chemists, because of shyness or because the assistant is a young female; that it would help reduce teenage pregnancy; and that the onus would then be on the young man to take precautionary action. The research project on male university students in Melbourne reported that a few men said they were shy about buying condoms.²²⁰ One submission mentioned that a free condom service for males under 20 in North Carolina had reduced conception and increased contraceptive use.²²¹ Professor Leeton told us that in the UK condoms are available at retail and barber shops and that in both the UK and the US they are available from dispensing machines.²²²

429. On the other hand some submissions strongly opposed dispensing condoms by vending machines. For example, the St Joans International Alliance felt that this would not contribute to a responsible approach to family planning.²²³ The fear expressed in these submissions is really that making contraceptives openly available

214. *Health (Contraceptives) Act* 1974, section 270L.

215. *Contraceptives Act* 1941–1972, section 2.

216. *The Health Act* 1937–1975, section 106 (1).

217. *Therapeutic Goods and Cosmetics Act*, 1972–1975, section 42.

218. *Pharmacy Ordinance* 1936–1975, sections 35, 41.

219. Submissions 556, J. Cole & F. Beighton; 204, Mrs M. J. Fullard; 210, WEL; 208, J. W. Gilmour.

220. Beighton & Cole, Commission research report, no. 5, p. 6/6.

221. Submission 73, Jo Wainer.

222. Evidence, pp. 812–13, Professor J. Leeton.

223. Submission 402, St Joans International Alliance; see also Submission 211, Knights of the Southern Cross.

will encourage promiscuity and experimentation by young people. This is a view which pays little regard to the sexual behaviour of the young and which we do not share.

430. The condom should be made available as widely as possible. It is one of the more effective means of contraception, when properly used, and it can help prevent the transmission of venereal disease; this reason alone prompted the Poverty Commission to recommend that it be more actively promoted particularly among young people.²²⁴ It is obtainable without going to a doctor and is therefore ideal for those who are unable or reluctant to seek advice.

431. In our view there should be no restrictions on the sale of non-prescription contraceptives either as to time or as to place; it should be made clear that condoms can be sold in any retail outlet or by vending machine.

Prescription requirements and paramedical personnel

432. In the 1930s Dr Stopes protested against proposed legislation to restrict contraceptive sale so that they would be available only on prescription.²²⁵ She pointed out that only half the women who bore children in those days saw the doctor. In her view the expert midwife was well fitted to examine and give advice on birth control. Her remarks were mainly in relation to the diaphragm—oral contraceptives are a comparatively recent development.

Oral contraceptives

433. Restrictions on sale of oral contraceptives are based on their classification as schedule 4 poisons: as such they are 'restricted substances' and obtainable only on prescription. In general only a medical practitioner can prescribe oral contraceptives and only a chemist or licensed person can dispense oral contraceptives. In some States medical practitioners may supply oral contraceptives.²²⁶

434. It was submitted to us that the legal requirement that oral contraceptives be dispensed on prescription inhibits the expansion of family planning services (and unnecessarily restricts access to contraception). Professor Shearman stated in evidence that prescription was:

... an unnecessary impediment to women having access to oral contraceptives.

He continued:

I would emphasise that the attitude I am expressing is that of the Australian Council of the College [Royal College of Obstetricians and Gynaecologists], which is an English college. The Australian Council have the attitude I have just stated.²²⁷

Professor Leeton said that he had mixed feelings on this issue. The side effects showed that many women should have their blood pressure monitored. On the whole, despite this, he would like to see the pill dispensed by machine.²²⁸ Others thought that oral contraceptives could be dispensed by trained personnel.²²⁹

435. Judith McLean, director of the Family Planning Association of NSW, told the Commission about the training of nurse practitioners working in family planning clinics. She made the following point:

... training of medical practitioners does not fit doctors to prescribe the pill ... we are training our nurse practitioners and we feel that they are better equipped to dispense what

224. *Social/medical aspects of poverty in Australia*, p. 161.

225. Stopes, 1935, pp. 55–8.

226. For full details see Finlay & Gleeson-Sihombing.

227. Evidence, p. 3085, Professor R. Shearman.

228. Evidence, p. 798, Professor J. Leeton.

229. Submission 73, Jo Wainer; Evidence, p. 1321, Dr Peter Hoopman; p. 3070, J. McLean; p. 2074, S. Wilson.

is sometimes termed a potentially dangerous drug than medical practitioners with no experience or knowledge at all. I would like to see the pill off script but into the hands of trained people who are perhaps not as expensive as doctors and have more understanding and sympathy in the prescribing of the pill.²³⁰

436. The practice of requiring oral contraceptives to be supplied only on prescription has been under review in other countries.²³¹ In countries where there are few doctors, the pill has often been made available without prescription (Pakistan, Iraq, China). In western countries physicians are generally of divided opinions as to the dangers of the pill and the benefits to be gained by permitting its liberal distribution.

437. A Joint Working Group on Oral Contraceptives set up in England, under the chairmanship of Baroness Robson, has concluded that nurses, midwives, health visitors and pharmacists should be allowed to prescribe the contraceptive pill after undergoing suitable training and under certain conditions. Medical histories are to be taken, blood pressure measured and doctors informed. To protect women at special risk from the pill, they did not recommend general sale over the counter or from slot machines.²³²

438. The Chief Medical Officer of the Family Planning Association in Great Britain, Dr Michael Smith, had earlier advocated that the task of prescribing the pill be delegated to trained nurses, midwives and health visitors, who would be able to reach women who fail to use a reliable form of contraceptive and thereby save the doctor's time. Professor Huntingford in the same publication wrote that provided women are fully informed about the small risk of the pill, it should be taken off prescription altogether, and be made available in slot machines, pubs and supermarkets. The author points out that in the absence of certain medical indications there is no way of predicting which women on the pill will suffer thrombosis. Some doubt whether women reluctant to approach a doctor would more readily approach a pharmacist.²³³

439. The Poverty Commission recommended that nursing staff in hospital clinics and community health centres should be able to dispense condoms and other non-prescription contraceptives and that the possibility of their prescribing oral contraceptives and inserting intra-uterine devices under the supervision of a doctor be seriously considered.²³⁴ They thought this would be useful for people in rural areas and for poor people who might have limited access to doctors in private practice, and especially for rural Aborigines.

440. In our section on contraceptive services we give support to the training and employment of nurse practitioners in fertility control services and the provision of insurance to cover their work. We suggest that steps should be taken to enable nurse practitioners to take a wider role in prescribing contraceptives.

441. At present, in Australia, a nurse must work under the supervision of a medical practitioner when providing family planning services. A doctor may delegate certain functions to nursing staff but remains ultimately responsible.²³⁵ In remote areas, and

230. Evidence, p. 3070, J. McLean.

231. Malcolm Potts, 'Laws regulating the manufacture and distribution of contraceptives: report of workshop on the manufacture and distribution of contraceptives', *Columbia Human Rights Law Review* 7, 1 (1975), p. 244.

232. *New Society*, 4 November 1976, p. 253 (the report of the Working Party is published by HMSO).

233. 'The pill off prescription' referred to in Submission 421, A. K. Henderson.

234. *Social/medical aspects of poverty in Australia*, p. 157.

235. K. Dunn, *Family planning and the nursing profession* (FPA, Victoria), p. 18; for a discussion of the role of paramedical staff in the dispensing of contraceptives, with special reference to oral contraceptives, see Allan G. Rosenfield, 'Laws relating to professional paramedical role in contraception', *Columbia Human Rights Law Review* 7, 1 (1975), p. 93.

for people with special needs, it will become increasingly important for nurse practitioners, community health nurses, infant welfare nurses, domiciliary visitors and other trained personnel to be able to provide a full range of services.²³⁶

442. We note that the risks of mortality and morbidity from the pill are very low. Nevertheless there are some matters that should ideally be checked. It is inadvisable for the very young or for the older woman to take the pill without being aware of the contra-indications. Instructions are also needed on the proper use of the pill and about side effects. For these reasons we think that the pill should be available only through a person trained to give information and advice on its proper use. We would not necessarily restrict the categories of such persons; they might include nurses, or other specially trained personnel, at family planning clinics, specially trained social workers, pharmacists and possibly others. It would be important to establish proper standards for training these personnel and for their competence to be recognised by the Commonwealth and States under appropriate legislation. This would require co-operation. The FPAs or other recognised training bodies could be authorised to issue certificates of competence to persons who have received the appropriate training; this would in turn authorise those persons to prescribe oral contraceptives.

443. When more is known about the oral contraceptive it is hoped that it will be possible to make it available without restriction.

The intra-uterine device and diaphragm

444. These must be fitted by a medical practitioner; in fact family planning nurse practitioners do this work at present under the supervision of doctors. For similar reasons to those set out above, we are of the view that trained nurse practitioners should be authorised to prescribe and fit both the diaphragm and the IUD.

Consumer protection

445. Several matters were drawn to our attention which suggest a need for legislation or regulation to protect the interests of people using contraceptives, both prescription and non-prescription products. The matters relate to advertising claims, quality of products and packaging and instructions.

Advertising claims

446. We received some complaints suggesting that advertising claims were often exaggerated and that, as a result, people were having sex without effective contraception.²³⁷ One spermicidal product is said to be 'at least as reliable as the diaphragm or sheath methods' and 'significantly more effective, when used as directed, than rhythm, withdrawal or the condom'.²³⁸ Figures quoted earlier in this report do not support this claim; they suggest a higher pregnancy rate for spermicides than for the diaphragm or condom. We do not know of any research studies supporting the claims. We have not taken up the matter with the distributors. We consider, however, that it is the responsibility of the government to investigate such claims and to ensure that they are either verified or withdrawn.

447. The possibility of proceeding under the *Trade Practices Act* 1974 for false claims should be considered. Section 53 prohibits a corporation from falsely representing that goods are of a particular standard or from representing that goods and services have performance characteristics they do not have.

236. Evidence, p. 2074, S. Wilson.

237. Submissions 421, A. K. Henderson; 619, ALRA.

238. These claims are made in respect of Delfen Foam, a product made in England by Ortho Pharmaceuticals Limited and distributed by Ethnor Pty Ltd Sydney ('Delfen' is a trademark).

Quality of products: standards

448. Control over the quality of contraceptive products manufactured in Australia is a matter of State or Territorial law. The Commonwealth has power in respect of goods which are imported, are the subject of interstate trade or are supplied to the Commonwealth or supplied as a pharmaceutical benefit.²³⁹ Under State laws persons manufacturing therapeutic or restricted drugs must be licensed. States generally accept the standards of the British Pharmacopoeia or British Pharmaceutical Codex.

449. Under the Commonwealth *Therapeutic Goods Act* 1966 standards may be set. A Therapeutic Goods Advisory Committee is appointed under the Regulations to consider standards. A Drug Evaluation Committee advises on imported contraceptives, but local products are not subject to Commonwealth regulation except in the cases mentioned.

450. The Tasmanian Legislative Council Select Committee on Therapeutic Goods, Health Foods and Cosmetics concluded that contraceptives should be as efficient as possible, and that quality control of non-prescribable contraception is inadequate. They recommended complementary State and Commonwealth legislation to regulate the manufacture, distribution, labelling and advertising of contraceptives and to provide standards. We support these recommendations. A joint Commonwealth-State committee should be established to set and enforce standards.

451. There is a special need to take action to ensure that non-prescription items are of good quality, particularly condoms. We think the use of condoms should be actively promoted, but it is essential that they comply with minimum standards.

452. There is as yet no Australian standard for condoms. Unofficial tests carried out on condoms available in Australia have found high failure rates.²⁴⁰ The Standards Association of Australia is now in the process of adopting an Australian Standard Specification for rubber condoms. The Standard requires adequate instructions for use, storage and expiry date. It also sets standards for materials, design, freedom from holes, bursting strength and packing and marking.

453. In our view the government has a responsibility to ensure that condoms do not enter the market in Australia unless they comply with appropriate standards.

Packaging and instructions

454. It is important that people be given adequate instruction in the use of all contraceptives. When they have to be prescribed there is an opportunity to do this, but it may not be taken or the information may be misunderstood or forgotten. Appropriate and easy to understand instructions should be included with all packages of contraceptive products. These should be in several languages.

455. In the case of the pill each packet should contain a list of contra-indications to the use of the oral contraceptive and adequate instructions on how to use the pill, including what steps should be taken if one or more pills have been omitted and the circumstances under which a doctor should be consulted. Other prescription items, such as the diaphragm, should also have adequate instructions. The FPA makes pamphlets available about all methods of contraception and most prescription products do contain instructions.

456. The need for instructions is even more important in the case of non-prescription items where the user may have had no contact with a doctor or counsellor. A recent survey carried out in Sydney found many inadequacies, ambiguities

239. For full details see Finlay & Glasbeek, part A, pp. 22-7.

240. Tests are reported by the Tasmanian Select Committee, and in *Some socio-medical aspects of sex* (Sydney Uni., Postgraduate Representative Association, 1973).

and complexities in oral contraceptive instruction sheets.²⁴¹ These findings led the Australian Federation of Family Planning Associations to write to drug firms to ask for clarification on a number of points, including how to take the pill correctly, when contraception is effective/ineffective and what to do if pills are missed.

457. The standards set for condoms should ensure that:

- (a) the packet is properly date-stamped with instructions on storage;
- (b) the packet contains instructions on use.

Appropriate requirements about packaging and instructions should apply to all contraceptives.

Pregnancy testing

458. At present pregnancy testing is done by medical practitioners, at hospitals, family planning and abortion clinics and by pharmacists. The law may vary from State to State; the position in NSW so far as pharmacists are concerned is that they may carry out tests using restricted substances but may not charge for materials or sell a test kit without a prescription.²⁴² The NSW pharmacists organisations have also laid down the following rules:

- (a) pregnancy testing should only be carried out by pharmacists who can demonstrate evidence of expertise in the use of diagnostic aids;
- (b) under no circumstances will diagnosis of pregnancy be undertaken by a pharmacist;
- (c) no advertising of pregnancy testing services is permissible, other than a display of a card within the pharmacy—the card to be no more than 100 mm x 230 mm and to carry no more than a simple statement that tests are carried out or conducted on the premises;
- (d) all tests must be carried out in an area physically separate from the dispensing area, and the testing area must be adequately equipped;
- (e) the results of any tests undertaken must be referred directly to the patient's medical practitioner.

459. Pregnancy testing is said to be a problem for some women whose doctors are unwilling or unsympathetic or who do not have ready access to a doctor, clinic or pharmacist.²⁴³ A Brisbane pharmacist, Pam Gorrington, spoke of the need to develop a reliable pregnancy testing kit available without prescription for women in remote areas or those who do not necessarily wish to approach their doctor.²⁴⁴ Such kits are available in some countries, but in Australia they could not be sold without a prescription because they contain scheduled substances.

460. The Lane Committee in the UK considered this issue and recommended that the Health Department either license or ban do-it-yourself kits.²⁴⁵

461. While there are advantages in testing being carried out at a specialised clinic, able to provide counselling and other services, there is also a need to ensure that women who do not have access to services are able to have a test done promptly and inexpensively. The Department of Health should encourage the development of a pregnancy testing service for women in remote areas or those who have no ready

241. Hawker, 1977, pp. 67–9; see also Submission 556, Cole & Beighton.

242. Dr A. Douglas, Medico-legal aspects of pregnancy tests (delivered at Monash Uni., July 1976).

243. Snyder & Wall, p. 29.

244. Evidence, p. 1544, Pam Gorrington.

245. Lane report, vol. I, para. 498.

access to services. Pharmacists could provide a postal service, or an efficient and easy to use self-kit could be developed for distribution without prescription. Proper standards would need to be developed.

Sterilisation—vasectomy and tubal ligation

462. The Poverty Commission drew attention to the uncertainty of the law relating to sterilisation and considered this to be a factor in the unwillingness of doctors to perform the operation.²⁴⁶

463. Family Planning Associations in NSW, Victoria and the ACT performed 867 vasectomies in 1975–76.²⁴⁷ It is generally thought that there are more female than male sterilisations. The Australian Family Formation Project found that 1.5 per cent of the married women respondents had been sterilised in 1970–71 and that 4.2 per cent altogether had been sterilised.²⁴⁸ Figures supplied to us by the Department of Health suggest that in the year 1976–77 up to 27 000 male sterilisations (vasotomy and vasectomy) and up to 38 000 female sterilisations (salpingectomies and other tubal sterilisation) were performed in Australia—a total of 65 000. These figures are estimated for a full year on the basis of figures from the Medical Benefits Schedule of Statistics. They relate to Medibank claims only and exclude public ward patients and clinics covered by health program grants. The full table is at Annexe IV.H.

464. Since 1971 the AMA:

... recognises the procedure as ethical if done for adequate reasons and with full knowledge by the patient, and presumably the spouse, of the consequences.²⁴⁹

It is common for the doctor to require both patient and spouse to sign a consent form before carrying out the procedure.

465. Voluntary sterilisation is not necessarily unlawful whether its purpose is therapeutic, eugenic or simply as a birth control method. It has been suggested that the consent of the patient may be immaterial to a charge against the doctor of assault. Professor Howard in *Australian criminal law* suggests, however, that when concerned with a voluntary surgical procedure there could be an exception to that rule:

... for the purposes of the law of assault [the victim] cannot consent to the infliction of bodily harm upon himself unless [the defendant] is acting in the course of a generally approved social purpose when inflicting the harm.²⁵⁰

The question of whether sterilisation is a 'generally approved social purpose' would in that case depend upon the interpretation of the courts.²⁵¹

466. The general provisions of civil law that require surgical operations to be performed in good faith and with reasonable care and skill would apply.²⁵² Questions

246. *Social/medical aspects of poverty in Australia*, p. 149.

247. Statistical summaries provided by AFFPAs.

248. Caldwell & Ware, *Population Studies* XXVII, 1 (1973), p. 12.

249. Finlay & Glasbeek, part B, p. 98.

250. Prof. C. Howard, *Australian criminal law* (Law Book Co., Sydney, 1971), p. 141.

251. Question of public policy discussed in S.S.W. Davis, *The problem of consent: abortion and sterilisation operations* (School of Health Administration, Uni. of NSW, 1972) pp. 38–9.

252. For a detailed discussion of the question see Finlay & Gleeson-Sihombing; T. Buddin, Lecturer in law, NSW Uni., The elusive right to voluntary sterilisation: a statutory panacea. For discussion of overseas trends—particularly the right to voluntary sterilisation in the USA—see Joan Lombard, 'Vasectomy', *Suffolk University Law Review* X (1975), p. 25; Mark J. Treacy 'Voluntary sterilisation: is legislation advisable?' in *New dimensions in legislation* (Notre Dame Law School, 1972), p. 256; James F. McKenzie, 'Contraceptive sterilisation', *University of Florida Law Review* XXV (1973), p. 327.

could arise concerning the civil liability of doctors where sterilisation fails and pregnancy occurs. Unless the failure is due to medical negligence, the question of possible action for malpractice should not arise.²⁵³

467. Submissions from the medical profession proposed that the present legal uncertainty regarding sterilisation be clarified. The South Australian Medical Womens Society said that often sterilisation was requested for family planning reasons where no medical condition existed. Later there may be a change of mind by the patient or the parties.²⁵⁴ The Australian Council of the Royal College of Obstetricians and Gynaecologists said that, although sterilisation could bring benefits to family life, the legal status of the procedure has not been defined. In their view the interests of the patient would be better protected if there were a carefully defined and valid form of consent; the simple forms now in use are not enough for a procedure which changes relationships.²⁵⁵ Other evidence put similar views.²⁵⁶

468. It was suggested by some that both the legal uncertainty and the attitudes of doctors led to sterilisation being difficult to obtain.²⁵⁷

469. One submission suggested that there should be no requirement for the spouse to consent to sterilisation.²⁵⁸ It was suggested by one woman that men were more willing for their wives to be sterilised than themselves²⁵⁹, and by another that, whereas a woman must get her husband's consent to tubal ligation, he does not have to get hers for vasectomy.²⁶⁰ No distinction is made in law between husbands and wives regarding consent. The FPAs consider consent to be desirable and in some cases they require it, in others not. They perform only vasectomies. Most tubal ligations are done in hospitals which usually require consent forms.²⁶¹

470. A study of current practice in regard to sterilisation was recently undertaken. The purpose was to discover how readily voluntary sterilisation for contraceptive purposes is available. General practitioners, gynaecologists, family planning counsellors and hospital doctors were interviewed. The summary reports that married persons of over 30 with two children had a good chance of obtaining a sterilisation at FPA clinics, and that it was more difficult to obtain sterilisation through a private doctor or hospital. The author concludes:

There is a decided lack of uniformity in procedures used and in preconditions regarded as essential, not only between doctors operating in different institutions but also on occasions between those working in the same institution. Fear of legal liability varies considerably, as does the individual doctor's understanding of the relevant law. Some doctors have been threatened with suit by subsequent spouses of the parties who have been sterilised.²⁶²

471. Recommendations have been made in the United States²⁶³ and Canada²⁶⁴ to clarify the law and thereby make access to sterilisation easier.

253. Stephan H. MacKauf, 'Birth control and malpractice', *Trial Lawyers Quarterly* 10, 2 (1974), p. 86.

254. Submission 143, SA Medical Womens Society.

255. Submission 112, RCOG, Australian Council.

256. e.g. Evidence, p. 1447, Sr G. Brooking.

257. Submission 535, Yvonne Foster.

258. Submission 619, ALRA.

259. Submission 307, Mrs S. Vaughan.

260. Submission 1117, Mrs J. E. Lowth.

261. Evidence, p. 1413, Prof. L. Cox said that consent was not insisted on.

262. Buddin (NSW Uni.), p. 23.

263. *Population and the American future*, Report of the Commission on Population Growth and the American Future, 1969-72, (US Govt Printer, Washington, 1975).

264. *Report of the Royal Commission on the Status of Women in Canada*, pp. 280-1; see also Submission 619, ALRA.

472. The Lane Committee's view was that, provided the operation is performed after due consideration, it can be an advantage to health and happiness and can benefit marriage by removing the fear of unwanted pregnancy. The Committee recommended that counselling be available before and after the operation; that it be not carried out without time for reflection except in an emergency; that it be confined to cases where there is medical or genetic reason to avoid pregnancy or where both parties are sure that they want no more children; that it never be a condition of terminating a pregnancy; and that consideration always be given to whether sterilisation of the woman or the man is more appropriate.²⁶⁵

473. The advantages of sterilisation as a means of fertility control, particularly but not exclusively where the family has been completed, are such that the legal doubts should be clarified. Where an adult male or female has consented to the operation the doctor should not be criminally liable, nor should he be civilly liable unless there is negligence. The Commission on the Status of Women in Queensland considered that there should be no legal impediment to sterilisation and recommended that the law provide that a medical practitioner may lawfully perform the operation on the request of an adult. They also thought that the AMA could draw up guidelines for doctors when doubts about the legality of the operation were resolved.²⁶⁶

474. We agree in general with this recommendation. We have considered whether there should be any protection for the younger person. Some people, especially the young, may decide hastily to be sterilised, a decision which may later be regretted. We therefore consider that persons under 21 should not be able to consent validly to sterilisation, and that a 'cooling-off' period of 6 months should be imposed on anyone under 25.²⁶⁷ Counselling should be available to anyone seeking sterilisation.

475. It is highly desirable that a married person should consult with his or her spouse about such a significant step as sterilisation. We do not consider, however, that this is a matter for legal regulation. Children should be wanted by both parents and neither should impose his or her will on the other to have children. If the parties are in disagreement about sterilisation this may indicate a risk of breakdown but it should not be a ground to refuse the operation. A doctor should not be civilly liable because the spouse has not consented to the operation.

476. Our observations should not be taken to imply that a doctor has an obligation to perform a sterilisation on the request of a patient. What is proposed is that the doctor should be free of liability if the operation is performed with due care in the circumstances indicated. The decision is to be made by the patient and doctor.

Mentally handicapped and sterilisation

477. A difficult situation can arise where parents or others seek sterilisation of a retarded or handicapped person. In November 1975 a case was reported in the Australian press of a 21-year-old woman who was sterilised at the suggestion of a gynaecologist because of the mother's fear that she might be molested and become pregnant.²⁶⁸

478. The South Australian Medical Womens Society mentioned this issue in their submission and proposed that where the patient is unable to comprehend the matter the guardian must be protected if the operation is performed. In their view a definition is needed.²⁶⁹

265. Lane report, vol. I, paras 533-5.

266. *Report of the Commission of Inquiry into the Status of Women in Queensland* (1974), pp. 10, 31.

267. Submission 619, ALRA suggested 4 months.

268. *Sunday Telegraph*, 23 November 1975.

269. Submission 143, SA Medical Womens Association; see also Evidence, p. 1412, Prof. L. Cox.

479. The issues were also considered fully in a recent English High Court decision, which involved an 11-year-old girl and a dispute between, on the one hand, the parents and doctor and, on the other, a psychologist. It was held that the decision to perform a sterilisation for non-therapeutic purposes on a minor could not be within the doctor's sole clinical judgment, that the proposed operation involved the deprivation of a woman's basic human right to reproduce, that the court would not risk damage which it could not repair and that the child should remain a ward of court. The Judge was of the view that the operation was neither medically indicated nor necessary and would not be in the daughter's best interests.²⁷⁰

480. It seems to us that the decision to sterilise someone who may not be able to understand what is being done is a very serious one, and a heavy burden for parents and medical practitioners. In some cases the indications will be strongly in favour of the procedure, while in others there may be doubts. The legal position needs clarifying for the benefit of medical practitioners, parents and the person concerned. If it were possible for independent legal advice to be obtained on behalf of the person concerned in cases of doubt this might ease the problem, but would add a further one of trying to define such cases. It might be possible to resolve the problem by requiring an application to the court backed up by medical and social reports.

481. We believe the matter should be further investigated and that the law should be clarified.

Infertility and artificial insemination

482. We received a few submissions about infertility. The legal and social problems of artificial insemination were raised by the Australian Council of the Royal College of Obstetricians and Gynaecologists. They said that the procedure was undefined legally, but that it is medically acceptable and that the results in terms of happiness are good. They submitted that legal protection is needed for the patient, the doctor and the child.²⁷¹

483. Although some case law has implied that AID procedures might constitute adultery, the removal of fault, by the Family Law Act, makes this aspect of law less important. Current issues relate to the legitimacy and status of the child and the possible liability of the doctor.²⁷²

484. In theory a child born as a result of AID may be considered to be illegitimate. In practice, provided the child is registered as a child of the marriage, with both husband and wife signing the documents for registration of the birth, no question of legitimacy need arise.

485. The general presumption that a child born to persons who were married at the time of the child's birth is legitimate may be rebutted. In practice the fact that the identity of the donor is generally kept secret by the doctor would mean that evidence that might rebut the presumption will not be brought to light.

270. *In re D* (a minor) Wardship: Sterilisation, WLR, February 1976, p. 279.

271. Submission 112, Australian Council, RCOG; see Evidence, p. 1413, Prof. L. W. Cox.

272. For further discussion of these issues see: Finlay and Gleeson-Sihombing; Finlay & Glasbeek, part A, pp. 89 ff; William A. W. Walters, Assoc. Prof of Obstetrics and Gynaecology, Ethical and legal problems of in vitro fertilisation and embryo transplants (Monash University, June 1976); Ninth Report of the Royal Commission on Family and Childrens Law, *Artificial insemination* (Vancouver, BC, May 1975); Dominique De Stoop, 'Human artificial insemination and the law in Australia', *Australian Law Journal* 50 (1976), p. 298; Marilyn Mayo, 'The legal status of the AID child in Australia', *Australian Law Journal* 50 (1976), p. 562.

486. Questions of custody and support may, however, arise where the parties to the marriage are subsequently separated or divorced. If the husband of the mother does not register the child as his, then the child may not be able to succeed to property of the husband unless expressly named in the will. Where the husband dies intestate, the right of an AID child to succeed to the husband's property could cause legal problems.

487. Medical problems relating to AID relate mainly to professional negligence. In practice it might be very difficult to prove negligence on the part of a doctor if an AID child was born defective. Problems could arise, however, if the medical history of the donor was not properly checked by the doctor.

488. The question of the husband's consent may be important if he later refuses to recognise the AID child as his own. Other legal questions, such as the laws which require the natural father of a child to be named, may also cause problems for the AID child and its parents.

489. The Federal Co-ordinating Committee of Obstetricians was recently reported as estimating between fifty and seventy-five AID procedures each week.²⁷³ This indicates a reasonably large number of such children with an increasing likelihood of legal problems.

490. The legal uncertainties attached to artificial insemination should be cleared up. Where both spouses consent the doctor should be free of criminal or civil liability, and the child should be in the same position as the natural child born to the consenting parties for all purposes. The *Family Law Act* 1975 and relevant State legislation should be amended to achieve this end.

273. *AMA Gazette*, January 1977.

3. Unplanned and unwanted pregnancies

Introduction

1. Our terms of reference require us to report on:

... the social, economic, psychological and medical pressures on women in determining whether to proceed with unplanned or unwanted pregnancies.

In this chapter we draw attention to the important distinction between unplanned and unwanted pregnancies, discuss the incidence of such pregnancies and consider some of the reasons why pregnancies are not wanted.

2. When pregnancies are classified for research purposes it is customary to describe them as 'wanted' or 'unwanted', 'planned' or 'unplanned'. Whether a pregnancy is wanted depends on the mother's (or the parents') reaction to the pregnancy after its occurrence, whether it is welcomed or at least accepted. Whether it is planned depends on whether the mother or the parents intended to have a child. A pregnancy which is wanted in these terms may have been planned or unplanned. An unwanted pregnancy is, however, usually unplanned.

3. It is artificial to try to fit all pregnancies into these categories. It is an oversimplification to imply that every pregnancy which occurs is either planned or unplanned. We commissioned a research project to investigate the basis of decisions about having children.¹ The project looked at the fertility decisions of couples and the influence of social norms and pressures on those decisions.

4. The report discloses that many couples take for granted that children follow marriage at some stage. This is a strong social expectation. Some could give their reasons for this: children were needed to complete a marriage; or to keep oneself alive; or interest in seeing children develop.

5. Since most people assumed that they would have children the only question was when. There were few specific plans dating the first attempt to get pregnant.² Most had been using contraception; few had specifically planned when to stop contraception. Some had had trouble with the pill and had stopped using it.

6. In the Melbourne survey of the Australian Family Formation Project in 1971, 38 per cent (888) stated that they had become pregnant at least once because they took a chance sometimes. Of these, 66 per cent didn't care very much if they became pregnant; 88 per cent of this group were quite pleased that fate took a hand and made them pregnant.³ Lack of precise planning extended to the number of children as well as to their timing. Some do not decide upon their completed family size until they attain that number.

7. We conclude that it should not be assumed that people consider pregnancy to be a matter for planning. Some pregnancies are planned deliberately, of course. Since contraception is conscious, those who abandon it to allow events to take their course have introduced an element of planning. Use of the pill injects planning, at least to the extent of deciding not to take it any more. Some pregnancies occur despite plans to

1. L. Richards, *Having families*, Commission research report, no. 14, 1976.

2. *ibid.*, pp. 104 ff.

3. Demography Department, Australian Family Formation Project, Melbourne survey, numerical and percentage distributions of responses (ANU, Canberra, 1972).

the contrary. Between a pregnancy which is actively planned (i.e. arising from a conscious act) and one which is definitely unplanned (i.e. a surprise or unintended pregnancy) there is a grey area of indecision, or rather absence of decision, about the number of children and their timing. This lack of decision could contribute to inconsistency in use of contraception.

Incidence and causes of unplanned pregnancies

8. Because of the factors mentioned earlier it is difficult to compare research results about unplanned pregnancies. They are usually defined as pregnancies not consciously planned by the mother.

9. Most reports of sample survey research which classify pregnancies as either planned or unplanned include unwanted pregnancies in the unplanned category. This is largely correct since very few unwanted pregnancies have been planned. The relative proportions of these two categories can be seen in the data from the United States National Fertility Survey 1966–70.⁴ In the period in question currently married women under 45 were surveyed. Forty-four per cent of births were said to be unplanned including 15 per cent said to be unwanted. The higher the level of education the lower the percentage of unplanned or unwanted pregnancies.

10. Although Westoff asserts, from a comparison of 1965 and 1970 National Fertility Survey data for the US, that unplanned fertility is declining⁵, the proportion of pregnancies which are unplanned is still high. In her 1970 English study, Cartwright found that one in every three pregnancies was unplanned⁶; Fraser and Watson, in the same country, reported that half of the pregnancies they sampled were unplanned.⁷

11. In a 5-year follow-up survey of 350 couples married in Hull in 1965–66, Peel reports that one-third of all pregnancies occurring in the follow-up period were unplanned.⁸

Table IV.21 Planned and unplanned pregnancies by parity

| Parity | Planned | Unplanned | Percentage planned |
|--------------------------------|---------|-----------|--------------------|
| 1st pregnancies | 195 | 85 | 70 |
| 2nd pregnancies | 133 | 67 | 66 |
| 3rd pregnancies | 36 | 30 | 55 |
| 4th pregnancies | 11 | 11 | 50 |
| 5th and subsequent pregnancies | 4 | 5 | 44 |
| All pregnancies | 379 | 198 | 66 |

Source: J. Peel, 'The Hull family survey II: family planning in the first 5 years of marriage', *Journal Biosocial Science* 4 (1972), pp. 333–46.

12. In Australia, the Melbourne survey of the Australian Family Formation Project found that 37.8 per cent of respondents pregnant at the time of survey had not hoped to become pregnant just when they did; 56.2 per cent of all earlier pregnancies of

4. *Population and the American future*, p. 97.

5. C. F. Westoff, 'The decline of unplanned births in the United States', *Science* 191 (1976), pp. 38–41.

6. Cartwright, 1970.

7. A. C. Fraser & P. S. Watson, 'Family planning—a myth?', *Practitioner* 201 (1968), pp. 351–3.

8. J. Peel, 'The Hull family survey, II: family planning in the first five years of marriage', *J. Biosocial Science* 4 (1972), pp. 333–46.

respondents in the sample were 'specifically wanted' at the time they occurred, suggesting that the remainder (43.8 per cent) were probably unplanned. Some of the wanted pregnancies may also have been unplanned.

13. Bearing in mind what was said earlier about planning of pregnancies, the incidence of unplanned pregnancies suggests that couples do not always control effectively the number and spacing of their children. Some unplanned pregnancies occur because contraceptive methods are not perfectly reliable. Tietze estimates that these:

. . . may be expected to occur within one year among 1.8–5.3 per cent of women using oral contraceptives with a reasonable degree of motivation. From 9 to 24 per cent of women relying on other methods could be expected to experience . . . [an unplanned pregnancy] in the first year.⁹

Unwanted pregnancies

14. An unwanted pregnancy is one which is not wanted by the mother during the pregnancy. Unwanted pregnancies may lead to mental distress, to abortion or to the birth of an unwanted child, though not all children born of unwanted pregnancies are or remain unwanted. The costs and consequences of unwanted pregnancies to the mother, the child and the community are a matter of public concern.

15. In December 1975, the Commission invited people who had been personally involved with an unwanted pregnancy to telephone their experiences.¹⁰ Some of the reactions which we recorded were as follows:

When I discovered I was pregnant I was ready to commit suicide.

I went to a country town for 7 months. I starved myself. I wanted the child to die.

The most frightening moment was when the newborn and unwanted child was put in my arms . . . I came very close to battering my own child. I could only care for him physically, not emotionally. I felt trapped . . . I had never wanted a child.

At times I just wished the child would be born dead.

16. Desperate reactions such as these to unwanted pregnancies are not rare.

Incidence of unwanted pregnancies

17. The Melbourne survey of the Australian Family Formation Project asked married women pregnant at the time of the survey how they reacted when they discovered they were pregnant; 19 per cent responded negatively and, of these, 2 per cent 'felt it was a disaster'. The percentages of all mothers surveyed who reported 'specifically not wanting' to be pregnant at the time of each pregnancy is shown in table IV.22.

Table IV.22 Percentages of mothers surveyed who specifically did not want to be pregnant at the time of each pregnancy

| Birth order | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|-------------|----|----|----|----|----|----|----|----|
| Percentage | 12 | 11 | 21 | 23 | 32 | 28 | 34 | 39 |

Source: Australian Family Formation Project, Melbourne survey, numerical and percentage distributions of responses (Dept of Demography, ANU, Canberra, 1972).

9. C. Tietze, 'The problem of repeat abortions', *Family Planning Perspectives* 6, 3 (1974), pp. 148–50.

10. For the purpose of investigating the phenomenon of unwanted pregnancy, the Commission defined an unwanted pregnancy as any pregnancy which was unwanted at any time *during* the pregnancy by either parent. Pregnancies unwanted until confirmed but wanted from the time of confirmation were not included and were not considered to be a serious social problem.

Calls about *unplanned* pregnancies were detected and excluded at the switchboard. These callers were requested to write in.

18. From a total of 6166 pregnancies which had occurred to the sampled population, 954 or 15.5 per cent were 'specifically not wanted' at the time they occurred. Of 284 pregnancies (4.4 per cent) respondents stated they would have 'preferred to have avoided it altogether'; since the children had been born in fact, this is probably a minimum figure.

19. An English study published in 1970 reported:

... just over a fifth of the mothers [sampled], 22 per cent, had had at least one pregnancy that at the time they did not want at all.¹¹

The mothers in this study were all married. Fifteen per cent of them said of their most recent pregnancy that they 'were sorry it happened at all'. They reported this feeling when their baby was between 4 and 9 months old. This study further reported that the incidence of these feelings was greater among women who had been using some form of birth control than among women who had not, and that these feelings were more likely to occur with a mother's third or subsequent birth.

Table IV.23 Reaction to pregnancy and birth order

| Birth order | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 or more |
|------------------------------|---|---|----|----|----|----|----|----|-----------|
| Sorry it happened at all (%) | 8 | 5 | 19 | 25 | 39 | 52 | 47 | 50 | 56 |

Source: A. Cartwright, *Parents and family planning services* (Routledge and Kegan, London, 1970), p. 13.

20. A smaller English study, in 1973, studied some unmarried mothers attending a hospital clinic and examined their reactions to their pregnancy. Of these mothers 56 per cent reported a negative reaction to their pregnancy, 30 per cent were uncertain as to how they felt and only 14 per cent claimed a positive response.¹² It is not known how many were living in stable relationships. Similar findings have been reported in the extensive national fertility surveys of 1965 and 1970 conducted in the United States.

21. For the 1965 survey, Bumpass and Westoff estimated that 19 per cent of all births occurring to married women under the age of 45 in the United States between 1960 and 1965 were unwanted.¹³ Unwantedness increased from 5 per cent of first births up to 50 per cent of sixth or later births. There was a sharp rise with third and subsequent births. The percentages for the period 1966 to 1970 were 15 per cent for the population as a whole.

22. Unmarried women may be expected to experience hostile feelings towards pregnancies more often than married women. However, national survey data for unmarried women are lacking.¹⁴ A small study by Shanmugan and Wood of 100 unmarried mothers in Melbourne was published in 1968. They reported that 'sixty-five had negative reactions towards their pregnancy' and of these 'twenty-eight had little interest in their baby'.¹⁵

11. Cartwright, p. 13.

12. J. F. Pearson, 'Social and psychological aspects of extra-marital first conceptions', *J. Biol. Soc. Sci.* 5 (1973), pp. 453-96.

13. L. Bumpass & C. Westoff, 'The perfect contraceptive population', *Science* 169 (1970), pp. 1177-82.

14. Greenleigh Associates, *Facts, fallacies and future* (a study of the Aid of Dependent Children Program, Cook Council, Illinois, 1960).

15. N. Shanmugan & C. Wood, 'Unwed mothers: a study of 100 girls in Melbourne, Victoria', *Aust & NZ J. Sociology* 6, 51 (1970).

23. When the percentages found in the above studies are translated into numbers for the whole of Australia, the size of the phenomenon can be seen.

24. In 1974 there were 221 769 live births within marriage and 23 408 live births to unmarried women.¹⁶ The total number of live births was, therefore, 245 177. This figure does not include stillbirths or miscarriages.

25. Using the rates reported in the surveys quoted above as a guide, an estimate of the number of unwanted pregnancies can be made, taking low values from the rates reported, that is 15 per cent of births within marriage and 30 per cent of ex-nuptial births. The figure of 30 per cent of ex-nuptial births is lower than rates shown in any of the studies, but, as large random surveys of unmarried mothers are not available for the Australian population, it is useful to work with a conservative estimate of the incidence of unwanted pregnancies. While this approach may underestimate the real dimensions of the issue, it does provide a minimum estimate.

26. On these assumptions, the estimated incidence of unwanted pregnancies in Australia in 1974 is shown in table IV.24.

**Table IV.24 Estimated incidence of unwanted pregnancies:
Australia 1974**

| | |
|--|---------|
| 15% of births within marriage | 33 265 |
| 30% of ex-nuptial births | 7 022 |
| Total estimated induced abortions ^(a) | 60 000 |
| <hr/> | |
| Total unwanted pregnancies | 100 287 |

(a) Some of these abortions may be induced for medical reasons and do not necessarily represent unwanted pregnancies.

27. As a conservative estimate, therefore, 100 000 pregnancies, or one in every three pregnancies which occurred during 1974, were unwanted. It does not follow, as mentioned already, that the children born of unwanted pregnancies remained unwanted.

Women at risk

28. We estimated that 15 per cent of births in marriage (33 265) and 30 per cent of births outside marriage (7022) result from unwanted pregnancies. There are also approximately 60 000 abortions annually. More than half of these involve single women. There is no really definite information to enable us to build up a picture of the groups most at risk of an unwanted pregnancy. The research suggests that there are more unwanted pregnancies occurring to married women than to single women.

29. Analysis of the research data mentioned, and of statistics relating to abortion patients, suggests that pregnancies are most likely to be unwanted when they occur to married women with more than two children and to young single women. More of the latter group appear to seek abortion.

Unwantedness—an unacknowledged problem

30. If unwanted pregnancies are occurring at a rate of 100 000 a year, is this a serious social problem? One opinion is that 'it is relatively rare that a baby is unwanted by its mother at the time of its birth'.¹⁷

16. ABS, *Births* (1974).

17. *Unplanned pregnancy*. Report of the Working Party of the Royal College of Obstetricians and Gynaecologists (HMSO, London, 1972).

It has been the experience of many of our members that the unwanted or unplanned pregnancy has become the wanted and much loved child.¹⁸

Many young girls have been pressured into marriage by the confirmation of a pregnancy . . . they often resent the ties of parenthood and have accommodation and financial problems. With rest in the post-natal period, and with the baby established in a good feeding behaviour routine, they adjust well and continue as mature parents.¹⁹

31. Other submissions and information from women who had experienced an unwanted pregnancy showed that the situation can change during pregnancy so that the mother is glad about the birth.

32. There are, however, several reasons why we should consider unwanted pregnancies as a serious social problem: first because so many of these pregnancies lead to abortion; secondly because of the social problems encountered by single mothers and parents of large families living in poverty; thirdly because of the potential emotional and relationship problems for mother and child where the child remains unwanted after birth. The first two points are well recognised but the problem of adjustment between mother and child is often overlooked in discussions of unwanted pregnancies. She may adjust to the situation but nevertheless she may remain discontented about it. Some mothers with unwanted pregnancies may not make the adjustment.

33. Pohlman is of the opinion that 'The GAF (Growth of American Families) studies' provide convincing evidence on a vast scale that many mothers do not 'get over' their 'unwanting feelings'. In a comprehensive review of the literature published prior to 1969, he notes that several studies show changes in women's feelings towards greater acceptance of their pregnancies as their pregnancies progressed, but concludes:

The major reason for changes from unwanted conceptions to wanted babies was the hiding of feelings.²⁰

34. Another US study links neonaticide (murder of the newborn child within 24 hours of birth) with unwantedness.²¹

35. In a review of the literature, Illsley and Hall concluded that:

Although many women who are refused abortions do adjust to their situation and grow to love the child, about half would still have preferred abortion; a large majority suffer considerable distress and a small minority (eventually) develop severe disturbance.²²

36. Evidence of this kind may be hard for many people to accept, given that the majority of mothers appear to be fulfilling the role of mother in an adequate and caring way. Evidence to this Commission, however, reveals that women experience considerable fear of revealing their feelings of hostility to pregnancy or children. Some of the comments we received were these:

I was made to feel frightfully ashamed of not wanting to be pregnant or have a child . . . I had to pretend it was wanted in order to survive socially in a small town . . . I never for one moment enjoyed his childhood . . . my husband couldn't understand it, he thought as soon as I was in the position of motherhood I would like it.

I refused to discuss the pregnancy or tell anyone . . . I went through the motions of caring only.

18. Submission 586, Catholic Womens League of NSW.

19. 'Unwanted pregnancy phone-in', written evidence from a voluntary organisation.

20. Pohlman, p. 243.

21. Phillip J. Resnick, 'Murder of the newborn: a psychiatric review of neonaticide', *Am. J. Psychiatry* 126 (1970).

22. R. Illsley & M. H. Hall, Psychosocial aspects of abortion: a review of issues and needed research (unpublished mimeograph, Aberdeen, Scotland, 1973).

I wanted to talk to someone but I did not dare tell anybody—not family. I would gladly have talked to a stranger.

I feel that I am still subject to social pressures. As a ‘respectable married woman’, I still feel unable to tell family or friends that I have had an abortion.²³

37. One of our witnesses, Ms Denise White, Secretary of the WA Abortion Law Repeal Association, made the following comment:

It is also a very brave woman who having been refused an abortion by a doctor who then later delivers the child and says: ‘Aren’t you glad you had it?’ says: ‘No’. We just don’t allow people to think along those lines. I feel from my own experience that ‘no’ would be the truth many times . . . I think this will come out later in all sorts of ways in the relationship with that child—over-compensation and that sort of thing can occur from there.²⁴

38. This testimony is supported by research material. In a Prague study of women who had twice requested and been denied abortion:

. . . 20 per cent of women, who openly admitted having had one or more abortions, denied ever having requested termination of that pregnancy which was eventually carried to term and produced a child about whose development the mother was being queried by the research team.²⁵

39. Some women and some parents may not be able to admit, even to themselves, that a pregnancy or a child is unwanted.

In general, the good parent in our culture is supposed to be one who wants children, at least a few of them. He is not supposed to kill people or even wish they would die . . . For many the wish that one’s child had not been born is threateningly close to the wish that he would die, or even the wish to kill him. Thus it may be necessary to get rid of—or ‘repress’—the idea that the child is unwanted and decide that he is wanted after all. Parents may practise contraception and fail; they may wish for an abortion or stillbirth; but they often convince themselves that they really wanted the youngster, at least eventually if not now.²⁶

40. In some cases the interests of the mother and child may be best served by these efforts towards acceptance and care for the child. This is not always the case, however. If a woman employs rationalisations to justify her feelings to herself or to others, this may inhibit her from recognising her situation and taking steps to change or cope with it.

41. Another consequence is that the problem is in danger of being denied by the woman concerned, her immediate family, her friends, her doctor and her counsellor. It may also be overlooked by those who make policy on fertility control services, welfare services, equal employment opportunities and the availability of child care.

42. The more socially unacceptable it is not to want a pregnancy, the more likely it is that women will deny they have these feelings, and that policy-making groups will also deny that these feelings exist.

43. At present many Australian women with unwanted pregnancies do not feel able to express their rejection of their pregnancy. Because of this, there is a general uncertainty about the nature and incidence of unwanted pregnancy, and the issue is in the main unrecognised by policy makers.

23. ‘Unwanted pregnancy phone-in’, evidence from four callers.

24. Evidence, p. 2047, Ms D. White.

25. Henry P. David, ‘Unwanted pregnancies: costs and alternatives’, in C. F. Westoff, J. Park Jr (eds), Commission on Population Growth and the American Future, Research reports, vol. 1, *Demographic—social aspects of population growth* (1972), pp. 440–66.

26. E. Pohlman, ‘Wanted and unwanted: towards a less ambiguous definition’, *Eugenics Quarterly* 12, 1 (1965), pp. 19–27; see also K. Menninger, *Love against hate* (Harcourt, Brace & Wald, NY, 1942); M. D. Chapman, *Management of emotional problems of children and adolescents* (Lippincott, Philadelphia, 1965), p. 18.

44. The problem of the unwanted pregnancy would become more visible if the expression of unwanting feelings were accepted for what they are. Current attitudes are ambivalent—recognising that an unmarried mother may give up her child (and even reject it from birth), but denying that a married mother may have similar feelings. It would be preferable to acknowledge openly that some pregnancies and some children are unwanted, rather than to suppress or ignore the expression of unwanting feelings.

Reasons why pregnancies are unwanted

The reasons women give for their pregnancies being unwanted

45. The major sources of information on the reasons women give for not wanting a pregnancy are derived from studies of women requesting abortion. There are some limitations to the interpretation of this material because women requesting abortion are not necessarily typical of all women with an unwanted pregnancy. In addition, women may present reasons for wanting an abortion which hide the real reasons because they desire to fit within the accepted legal grounds on which abortion may be obtained. For example, in South Australia, where abortions may only be obtained on medical and psychological grounds, 88.3 per cent of abortion patients in 1971 had their operations on psychiatric grounds.²⁷ This compares with only 47 per cent of Preterm (Sydney) patients who stated that continuation with the pregnancy would have precipitated an emotional disturbance.²⁸

46. In a Melbourne survey some relatively well-off women stated that they could not afford another baby, leaving open the question whether they feared a drop in standard of living or whether this reason concealed another. In the study, of 5000 patients seen at the Melbourne Fertility Control Clinic, Wainer states:

Regardless of the stage of the pregnancy when women present for abortion, their overwhelming reasons are socio-economic. Financial problems were quoted by three-quarters of women, followed in order of precedence by disruption of future plans, the social stigma of being unmarried, the emotional relationship which led to the pregnancy had broken down, or just that the woman was already having problems coping with her life style.²⁹

47. In the study of patients presenting at Preterm in the period June to October 1974, Wall notes that 'many women had multiple reasons for terminating their pregnancies'. A classification of these reasons is shown in table IV.25.

48. An unpublished study of patients attending the Womens Hospital at Crown Street, Sydney, for abortion in the same time period also reported a multiplicity of reasons.³⁰ These are shown in table IV.26.

49. One reason for the variation between these studies may be that the Crown Street patients were more often from lower socio-economic groups than the Preterm and the Fertility Control Clinic patients, and may have felt the need to establish legal grounds for an abortion on the basis of their future psychological health.

50. Since failure to deal with socio-economic problems may also precipitate emotional disturbances, the two categories overlap. The category chosen will depend not only on the importance which the pregnant woman attaches to her reasons but also on the perceptions of her interviewer or counsellor.

27. A. F. Connon, 'Trends in legalised abortion in South Australia', *MJA*, 3 February 1973, p. 231.

28. S. Wall & C. Kerr, Comparative study of women having abortions—before and after Preterm (paper presented to conference on 'Womens health in a changing society', Brisbane, 1975; copies: School of Public Health and Tropical Medicine, Sydney Uni).

29. Wainer, *La Trobe Sociology papers*, no. 8 (1975), p. 21.

30. J. Banfield, Crown St Sydney (unpublished; copies: School of Public Health and Tropical Medicine, Sydney University).

Table IV.25 Reasons for pregnancy being unwanted, Preterm, 1974

| Reasons | Percentage of women stating each reason |
|---|---|
| Current inability to manage financially with a pregnancy | 60 |
| Continuation would have precipitated an emotional disturbance | 47 |
| Family size complete/recent baby | 20 |
| Too young to bear children | 18 |
| A desire to continue a career or studies | |
| No wish for forced marriage | Percentages not given but in decreasing frequency |
| Discontinuation of a relationship | |
| Pregnancy hazardous because of ill health | |
| Did not wish baby to be adopted | |
| Worries that child would be deformed | |

Source: S. Wall & C. Kerr, Comparative study of women having abortions—before and after Preterm (paper presented to IWY conference on 'Womens health in a changing society', Brisbane, 1975).

Table IV. 26 Reasons why pregnancy unwanted, Crown St Hospital, 1974

| Reasons | Percentage of women stating each reason |
|---------------------------------|---|
| Unable to cope emotionally | 80 |
| Could not cope financially | 62 |
| This would be an unwanted child | 47 |
| Could not face adoption | 12 |

Source: J. Banfield, Crown St Hospital (copies: School of Public Health and Tropical Medicine, Sydney University).

51. A survey of women seeking medical termination of pregnancy through the Children by Choice referral agency in Brisbane was carried out for the Commission.³¹ The project coded information about 3000 clients covering social, economic, demographic and psychological factors relating to the client's request for a termination of pregnancy. The reasons given for termination are shown in table IV.27.

52. In the 2 days of the Commission 'unwanted pregnancy phone-in', over 400 calls were received relating to pregnancies which were not merely unplanned but unwanted. Information gathered in this 'unwanted pregnancy phone-in' came from men and women and in most cases they were talking retrospectively about pregnancies. The Commission was told about unwanted pregnancies that had occurred from as long ago as 1919, although most of the pregnancies referred to had occurred in the last 10 years. Other callers were still pregnant. Of the 400 callers, 213 were interviewed over the phone and a questionnaire was completed for each. (The remainder did not leave phone numbers, could not be contacted in the ensuing weeks, or elected to write in.) Many of the pregnancies did not result in abortion and this should be considered when comparing results.

53. The information which came from the 'phone-in' is shown in tables IV.28 and IV.29.

31. Rigg, Commission research report, no. 4.

Table IV.27 Reasons for termination, Children by Choice, Brisbane

| Reasons | Percentage of women stating each reason |
|--|---|
| Doesn't want a child yet | 18 |
| Doesn't want any more children | 22 |
| Doesn't want to marry yet | 14 |
| Unhappy marriage | 3 |
| Wants to continue career/studies | 7 |
| Worried child will be deformed | 2 |
| Pregnancy hazardous (ill health etc.) | 4 |
| Doesn't want parents to know/family problems | 7 |
| Relationship discontinued (de facto left etc.) | 6 |
| Pregnancy result of extra-marital sex | 4 |
| Could never consider adoption | 2 |
| Only solution | 0.5 |
| No affection for man involved therefore doesn't want child | 3 |
| Couldn't manage emotionally | 14 |
| Couldn't manage financially | 36 |
| Other | 5 |
| Medical grounds (mental) | 1 |
| Medical grounds (physical) | 2 |
| Too young | 14 |
| Too old | 5 |

Source: S. Rigg, Clients of Children by Choice, Brisbane, Commission research report, no. 4, 1976.

Table IV.28 Reasons why pregnancy unwanted, RCHR 'phone-in', 1976

| Reasons | Percentage of women stating each reason |
|---|---|
| Not in a supportive relationship | 52 |
| Financial problems | 32 |
| Immediate problems of coping | 27 |
| Career/study considerations | 22 |
| Feels childbearing stage is over/family size complete | 19 |
| Afraid of social consequences | 16 |
| Pre-existing or precipitated physical or mental illness | 10 |
| Too old for childbearing | 6 |
| Wanted pregnancy at a different time | 5 |
| Too young for childbearing | 4 |
| Never wanted any children | 3 |
| Pregnancy the result of rape | 2 |
| Other | 12 |

54. These results may be compared with the findings of the Family Formation Project survey in Melbourne, in which women pregnant at the time of the survey were asked 'What is the main disadvantage of being pregnant now?'. Their responses are shown in table IV. 30.

Table IV.29 The percentage of each age group mentioning each reason for unwantedness

| Age at time of unwanted pregnancy | Not in supportive relationship | Financial problems | Problems of coping | Career complete | Family size complete | Social consequences | Illness | Too old | Wanted at another time | Too young | Never wanted | Rape | Callers in each age group | Number of callers |
|-----------------------------------|--------------------------------|--------------------|--------------------|-----------------|----------------------|---------------------|---------|---------|------------------------|-----------|--------------|------|---------------------------|-------------------|
| 15-19 | 95 | 42 | 8 | 26 | 0 | 47 | 3 | 0 | 3 | 16 | 0 | 5 | 18 | (38) |
| 20-24 | 73 | 32 | 13 | 37 | 3 | 19 | 2 | 2 | 3 | 3 | 7 | 3 | 29 | (62) |
| 25-29 | 42 | 37 | 37 | 20 | 10 | 5 | 17 | 0 | 5 | 2 | 7 | 0 | 19 | (41) |
| 30-34 | 26 | 26 | 51 | 9 | 43 | 6 | 14 | 3 | 9 | 0 | 0 | 0 | 16 | (35) |
| 35-39 | 0 | 29 | 57 | 7 | 29 | 0 | 36 | 7 | 21 | 0 | 0 | 0 | 7 | (14) |
| 40-44 | 7 | 21 | 29 | 7 | 64 | 0 | 14 | 64 | 0 | 0 | 0 | 0 | 7 | (14) |
| 45-49 | 0 | 50 | 0 | 0 | 100 | 0 | 0 | 50 | 0 | 0 | 0 | 0 | 1 | (2) |

Source: 'Unwanted pregnancy phone-in', RCHR, 1976.

Table IV.30 Disadvantages of pregnancy, FFP, 1971

| Reasons | % response |
|---|------------|
| Financial problems | 16 |
| Wife could not go on working | 12 |
| Strain on physical health | 7 |
| Too soon after last baby | 6 |
| Would tie mother or parents down too much | 5 |
| Strain on mental health or emotions | 3 |
| Too old | 2 |
| Didn't want any more children | 2 |
| Too soon after marriage | 1 |
| Too long after last child | 1 |
| No disadvantages, marvellous | 31 |
| Don't know | 9 |
| Other | 5 |

Source: Demography department, ANU.

Summary

55. Despite differences in the sources of data and classification of reasons, the studies cited above present a consistent picture of why pregnancies are sometimes unwanted. Neither physical ill health nor serious mental illness are commonly given as reasons, although these factors are important when they do occur. The main problem cited is an anticipated inability to cope with the care of the child born of the pregnancy. This is expressed in terms of the absence of supportive relationships, the anticipated social pressures and stigmas involved for the unmarried, and pressing financial or other circumstances such as inadequate accommodation or the presence of too many other young children already. Such phrases as 'unable to cope emotionally' (table IV.26) and 'continuation would have precipitated an emotional disturbance' (table IV.25) in all probability refer not to the onset of psychiatric disease but to the emotional effects of the struggle to cope in hostile or difficult circumstances. The 'phone-in' showed that the problems of immediate circumstances generally appear to be more important than considerations of desired family size, or the fact that the pregnancy has occurred at the wrong time.

56. The reasons 'family size complete' or 'child-bearing stage over' were important, however, to women over the age of 30. More women aged 25 and over thought they would have problems of coping than did women aged 15-24. Women in the lower age group were more likely to consider the lack of a supportive relationship and work-career considerations as important reasons. The social consequences of the pregnancy were most important to the 15-19-year-olds and appear to become less important with age. Financial problems, however, were mentioned by all age groups (table IV.29). In the 'phone-in' a small proportion (3 per cent) of women stated that they had never wanted any children. A further 2 per cent of the 'phone-in' respondents did not want their pregnancy because they had conceived as a result of rape.

Underlying reasons for unwanted pregnancies

57. Where unwantedness relates to immediate circumstances and these can be defined and analysed, there are prospects of introducing policies which might affect those circumstances and thereby remove the cause of unwantedness. This however may not be the whole answer. Substantial changes of social policy would be necessary to alleviate financial problems. Some problems of coping could be solved if house-keeping or other assistance were available. Not so easily remedied are circumstances such as those of the woman who feels she already has too many children, is too old for

childbearing or has a pre-existing mental or physical illness or handicap. More than half the 'phone-in' respondents thought that a supportive relationship was important in carrying through a pregnancy. It is also possible that in some cases there are other underlying reasons of a long-term nature; two of these are discussed below.

Voluntary childlessness

58. Seven (3 per cent) respondents to the 'unwanted pregnancy phone-in' stated that they had never wanted to have a child. This reason is not found elsewhere in the studies cited; this may be because women are reluctant to state that they want no children, because it is generally considered socially unacceptable.³² We do not suggest that this phenomenon is widespread; rather that where it arises it is unacknowledged or hidden.

59. Amongst the Melbourne respondents only 2.6 per cent had chosen to have fewer than two children (i.e. no children or one child) and of these a quarter had done so upon medical advice or because of an adverse hereditary condition. Fewer than 0.5 per cent of wives had chosen to have no children when healthy and in stable marriages. Five per cent of wives, when specifically asked about this, said they would have been prepared to 'consider having no children'; the majority would only have considered remaining childless if their health or hereditary disease made it desirable.

60. The couples interviewed in our study of decisions about having children considered that childlessness was selfish.³³ The assumption was that everyone who gets married has children.

61. Those who prefer to remain childless may be under some pressure not to say so.

62. The evidence from the 'phone-in' suggests that the wish to remain childless can be a reason why a pregnancy may be unwanted.

My husband talked me into taking a risk and then got me pregnant so that I would marry him . . . I felt cheated because I was tricked into pregnancy . . . I had wanted to enjoy a relationship with this man and never wanted a child.

Both my pregnancies were unwanted because of our own feelings. I don't like the idea of childbirth, my husband is not keen either.

63. Although it is not intended to discuss the basis for this feeling in this report, we do not accept the view that 'women who do not want children are usually psycho-sexually immature and reject to some degree the feminine role'.³⁴

64. This attitude, which rests on assumptions about the role of women, discourages women from revealing their true feelings. Consequently, when these feelings are revealed they are regarded as abnormal. In our view the desire to remain childless should be taken account of as a possible reason for not wanting a pregnancy.

The motherhood role

65. Difficult and hostile social and economic circumstances surrounding a pregnancy are the reasons most frequently given for unwantedness. These reasons are of great importance to the pregnant woman because she will usually bear the responsibility for the care of the child. In giving these reasons women are anticipating difficulty in coping with this responsibility. Fully 51 per cent of respondents to the 'phone-in' mentioned the absence of a supportive relationship as a reason for not wanting the pregnancy.

32. J. E. Veevers, 'The violation of fertility mores: voluntary childlessness as deviant behaviour', in C. Grindstaff & P. Whitehead (eds) *Deviant behaviour and societal reaction* (Holt, Rinehart & Winston, NY, 1972), p. 587.

33. Richards, Commission research report, no. 14.

34. W. S. Kroger & S. C. Freed, *Psychosomatic gynaecology* (Wilshire, Hollywood, Calif., 1962; reprinted edition of 1951 publication by Saunders, Philadelphia).

66. Research studies suggest that some women do not desire the change in life style which comes with motherhood. Williams and Hindell noted several 'covert reasons' for wanting to terminate a pregnancy, centring mainly upon the likely impact of a baby on the woman's life. These reasons included:

. . . sometimes the feeling that the mother herself would not be able to cope psychologically and physically with another baby.³⁵

67. The women experiencing these 'covert reasons' were anticipating the motherhood role as a source of stress because of a loss of present life style and because of the restricting and stressful nature of the motherhood role itself.

68. The motherhood role imposes many constraints on location, movement and choice of activities and is perceived to override most other roles in its importance.

69. Constant care of an infant cannot be postponed or neglected, and much of this care takes place in the home. This may have the effect of isolating the mother from social contact which most people experience at work.

70. Despite these restrictions, many women accept the role of motherhood gladly. For other women, however, anticipation of the usual stresses of the traditional motherhood role may be a reason for not wanting a pregnancy. For them, it is the role of motherhood rather than the child which is unwanted.

71. Changes are possible for women with co-operative husbands willing to take a large part in the care of children, those with money to buy child care or those who are lucky enough to live where the local council assumes some responsibilities for child care. As one woman wrote to the Commission:

The rich do not have a problem. When they are fed up with the children, they can afford housekeepers, baby-sitters etc.³⁶

Pregnancies unwanted by the father

72. Fathers may also not want pregnancies. In the Melbourne survey for the Australian Family Formation Project, 19 per cent of married women respondents pregnant at the time of survey reported negative reactions to the discovery that they were pregnant. This compares with only 12 per cent of husbands as reported by their wives.³⁷ No similar data are available about the fathers of ex-nuptial pregnancies. Other writers suggest that women usually feel more strongly about contraception and unwanted pregnancies than men.³⁸

73. Sometimes, however, fathers do not want pregnancies whilst they are very much wanted by the mother. One male caller during the 'unwanted pregnancy phone-in' claimed that his wife was pregnant for the third time despite his expressed wish never to have a child. He claimed that this third child would cause the break-up of the marriage.

74. Men who find a pregnancy unwanted may wish to remain childless to avoid the stresses of the father role, or they may consider that their present circumstances will hinder the performance of that role. Rejection of pregnancy by the father for various reasons, including not wanting to marry the girl, may lead to pressure on her to have an abortion; this is something which needs to be considered in counselling abortion patients. Pressure on him to marry can also have disastrous results for both.

35. J. M. Williams and K. Hindall, 'Abortion and contraception: a study of patients' attitudes', *PEP Broadsheet* 38, 536 (1972), pp. 13-17.

36. Submission 450, Mrs Joyce I. Robertson.

37. Demography Department, ANU, 1972.

38. L. Rainwater, *And the poor get children* (Quadrangle, Chicago, 1960).

Costs and consequences of unwanted pregnancies

75. There are consequences for the mother, the child, the family unit and the community when a child born of an unwanted pregnancy continues to be unwanted.

Consequences to the mother and her relationships

76. When a woman decides to maintain an unwanted pregnancy and keep the baby sometimes there is a happy outcome for all. But where she remains reluctant to assume her role she is likely to experience stress. The stress is likely to relate to the reasons why the pregnancy was originally unwanted, e.g. lack of money or absence of a supporting relationship.

77. When any stressful situation cannot be avoided, a person may feel anger, grief and resentment at the loss of control over his or her life. If the situation continues, the end result is often anxiety, helplessness and depression³⁹, and, rarely, suicide.⁴⁰

78. There is evidence for this association between depression and the unavoidable stress of the maternal role.⁴¹

79. As many as one in four mothers in the first year after giving birth have reported depression and one in 500 experienced post-partum psychosis. Studies indicate that the unwantedness of the pregnancy is a real factor here.

80. The stress of the mother role may result in fatigue and physical illness, guilt and more acute mental illnesses.⁴² The woman may also suffer emotionally from the failure to achieve potential in areas of personal ambition. Costs to the mental and physical health of the mother are costs to marital harmony.

81. One of our submissions said that anxiety is characteristic of early pregnancy and should not be taken advantage of to persuade a woman to have an abortion.⁴³ Other submissions made such assertions as:

We firmly believe that the traditional role of women, that of homemaker, giver of life, protector of the family, remains the *instinctive* role of a woman who chooses to marry . . . Upgrading of women cannot be achieved without defining sex roles in marriage, and cannot be achieved without recognising women's *natural* role.⁴⁴

Some women, however, are not happy in this role.

82. Other submissions asserted the view that adherence to traditional sex role stereotypes was damaging to human relationships and to the happiness of women. For example, the Commission on the Status of Women, NSW State Council of the Australian Council of Churches, noted:

. . . pressures on girls not to develop talents which do not lead directly to marriage . . . the encouragement of women to assume dependent roles . . . the cultural conditioning of women to think that true femininity requires only passivity . . . male and female concentration on the sexuality of women instead of their whole person [and] . . . the image of woman as male ego-booster.

39. M.E.P. Seligman, *Helplessness* (Freeman, San Francisco, 1975).

40. R. McMurdo, 'Pregnancy and suicide', *Modern Medicine of Australia*, 17 February 1975, pp. 49-52.

41. W. R. Gove, 'The relationship between sex roles, marital status and mental illness', *Social Forces* 51 (1972); C. Cline-Naffziger, 'Women's lives and frustration, oppression and anger: some alternatives', *J. of Counselling Psychology* 21, 1 (1974), pp. 51-6.

42. Gove, 1972.

43. Submission 197, ACT Right to Life Association.

44. Submission 586, Catholic Womens League, NSW.

The Commission concluded:

We believe that a deliberate effort must be made throughout society, particularly through the education system and the media, to break down sex role stereotyping.⁴⁵

83. We believe that greater sharing by mother and father and community participation in some aspects of child care now performed by one of the parents would help to remove some of the stresses of the traditional mother role and ease the circumstances of individual mothers.

Consequences to the child and the family

84. The consequences to the child born of an unwanted pregnancy arise from the difficulties the woman may have in coping with the stress of motherhood.

85. The woman in this situation is likely to see the child as an obstacle to her health and well-being. Menninger writes from his clinical experience:

Nothing is more tragic, more fateful in its ultimate consequences, than the realisation by a child that he is unwanted.⁴⁶

86. Social worker Bridget Gilling, in evidence to us, said:

An unwanted mother produces an unwanted child, and an unwanted child, in my simple observation . . . has a bad start in life and in many cases a bad continuation in life.⁴⁷

87. We stress again that a distinction must be drawn between the unwanted child and the child whose parents cannot cope:

It is far too simple to talk of them as having unwanted children. Those children are wanted and needed, even though the parents do not cope with them.⁴⁸

88. Sometimes there is an overlap. For example, there is a relatively high level of poverty among lone mothers and large families. The former group includes a number of single women whose pregnancies may have been unwanted.

89. The effects that unwantedness has on the child have tended to go unmentioned in the debate on abortion in this country. These consequences are not taken into consideration when assessing a woman's request for abortion.

90. Much of the evidence on the consequences to the child born of an unwanted pregnancy comes from studies of women denied abortion.⁴⁹ Although previous denial of abortion is an imperfect indicator of the subsequent unwantedness of the child, few studies have yet been undertaken in which the unwanted child has been identified in any other way. Moreover, it has been shown consistently, in studies from a number of countries, that:

- (a) unwantedness before birth is more likely to be associated with unwantedness after birth than is wantedness before birth;⁵⁰
- (b) children born of unwanted pregnancies are more likely to exhibit social and psychological disadvantage;⁵¹

45. Submission 991, Commission on Status of Women, NSW State Council, Australian Council of Churches.

46. Menninger, 1952.

47. Evidence, p. 396, Ms Bridget Gilling.

48. Rev. P. J. Hollingworth, 'The underprivileged in society', *Australian Family Physician* 2 (1973) pp. 394-7.

49. For a comprehensive review of the psychological consequences of denied abortion see Annexe IV.P.

50. Pohlman, 1969, pp. 237-56.

51. Z. Dytrych, Z. Matejcek, V. Schuller, H. P. David & H. L. Friedman, 'Children born to women denied abortion', *Family Planning Perspectives* 7, 4 (1975).

(c) unwantedness is frequently a factor in the history of people with mental illness.⁵²

91. The most reliable study of the consequences of unwantedness to the child born of an unwanted pregnancy was conducted in Prague on a sample of children born to women denied abortions matched with a similar number of other children. The report concluded that:

... overwhelmingly, although usually by only a small aggregate mean difference, three separate groups of observers—mothers, teachers and classmates—tended to give the study children less favourable ratings on personal characteristics than they gave the control child. One may conclude that a real tendency toward poorer adjustment is manifest in these data.⁵³

92. It was pointed out in the report that boys were apparently more endangered than girls.

93. The Prague study supports the findings of an earlier Swedish study by Forssman and Thuwe.⁵⁴

94. A number of other writers, assessing clinical experience, indirect research evidence and the incidence of overt gestures of unwantedness, such as abandonment, concur that unwantedness during pregnancy is a considerable and continuing hazard for the child.⁵⁵

95. It has been shown that child abuse is associated with the unwantedness of the child.⁵⁶ Children abandoned, put into homes, fostered, given up for adoption at a late age, beaten or otherwise physically or verbally abused are often (but not always) the unwanted children of unwanted pregnancies.

96. There are other consequences for the unwanted child that are frequently overlooked, for example mental and physical handicaps which may ensue from unsuccessful attempts at abortion, malnutrition in pregnancy and the lack of pre-natal care during pregnancy. Conversely, over-mothering due to extreme guilt may be a consequence.

97. While we have no definite information on how many children born of unwanted pregnancies are likely to become wanted children, studies suggest it may be no more than half.⁵⁷ The remainder who are not wanted by their mothers are unlikely to develop as well as those who are wanted.

Costs to the community

98. Costs to individuals become costs to the community when the individual places demands on community resources or when the individual's contribution to the community, for example in work, is reduced.

52. M. Beck, 'Abortion: the mental health consequences of unwantedness', *Seminars in Psychiatry* 2, 3 (1970); R. A. Schwartz, 'The role of family planning in the primary prevention of mental illness', *Am. J. Psychiatry* 125 (1969).

53. Dytrych et al., 1975, pp. 165-8.

54. H. Forssman & I. Thuwe, 'One hundred and twenty-eight children born after application for therapeutic abortion refused', *Acta Psychiatrica Scandinavica* 42, 71 (1966).

55. M. Beck, 'The destiny of the unwanted child: the issue of compulsory pregnancy', in Carl Reiterman (ed.) *Abortion and the unwanted child* (Springer, NY, 1971); Pohlman, 1969, pp. 306-28; David, in *Demographic-social aspects of population growth*.

56. See Part V, chapter 10.

57. Illsley & Hall, 1973.

99. An English study examining community costs concluded:

. . . that in a number of areas the child who is likely to have been unwanted, and his parents, places a much greater than average burden on health and welfare resources.⁵⁸

An American study also noted the high costs to the community of abandoned children and foster care.⁵⁹

100. The Forssman and Thuwe study in Sweden found that more unwanted than wanted children were placed in foster homes or childrens homes; had received psychiatric care; had been registered with child welfare boards for delinquency; had received public assistance; and had failed to achieve their intellectual potential as measured by the pursuit of theoretical studies. Likewise, the Czechoslovakian study reported greater use of health services and poorer academic performance by unwanted children. Higher risks were also reported for these children's emotional and social development and the incidence of divorce, pregnancy and widowhood were also more common for the partners of these children.⁶⁰

101. The medical, psychological and social costs to the mothers and families of unwanted children may also be passed on to the community. To the extent that the unwanted child is likely also to be a third or subsequent child⁶¹, the mother may require greater than usual use of health services.

102. In Australia many publicly funded welfare resources are available to people in stress with unwanted children. These range from the supporting mothers benefit to marriage guidance counselling.

103. The costs to the community may continue into the future. The unwanted child may be emotionally and socially less well adjusted than his wanted counterpart. Costs may flow on to the community when the child becomes an adult if he becomes involved with crime, further unwanted pregnancies, child abuse, marital friction and divorce, and mental and physical illness. It can become a self-perpetuating cycle of deprivation.

Unwanted pregnancies and the options

104. When an unwanted pregnancy is confirmed, a woman must make a decision of lifetime consequence. This decision is whether or not to proceed with the pregnancy and, if the pregnancy is continued, whether or not to keep the child. There are a number of courses of action which a woman who has an unwanted pregnancy may contemplate. The main ones are: maintaining the pregnancy and keeping the child, abortion and adoption or fostering. Infanticide and suicide occur occasionally, but we do not consider these.

The options

Marriage

105. In some cases an unwanted pregnancy leads to a marriage between the couple. This is more likely to occur among younger people. A recent research study by L. T. Ruzicka shows that in the period 1970-72 about three-fifths of 16-year-old brides, over half of 17-year-olds, and more than one-third of 18-year-olds were pregnant at the time of marriage.⁶² During the same period, more non-married women were

58. Laing, *PEP Broadsheet* 38, 534 (1972) p. 6.

59. David, in *Demographic-social aspects of population growth*, pp. 449-50.

60. Dytrych et al., 1975.

61. Cartwright, 1970; Demography Dept, ANU, Australian Family Formation Project, 1972.

62. L. T. Ruzicka, 'Pre-marital pregnancies in Australia'; to be published in *Journal of Marriage and the Family*, May 1977.

pregnant than had been the case previously.⁶³ It is reasonable to assume that some of these pregnancies were unwanted by either party.

106. Marriages which occur between young people under 20 where the girl is already pregnant are marriages which have a risk of breakdown higher than average. Unfortunately it is often the case that further children are born before the breakdown and separation. Marriage should not be undertaken lightly where an unwanted pregnancy occurs. It is clearly important that young couples contemplating marriage in this situation have access to and be encouraged to seek counselling, and some opportunities also to learn about the responsibilities which they will face.

De facto relationships

107. Some women who have unwanted pregnancies are already living with or plan to live with the father of the baby. The outcome of this choice will depend on the readiness of both parties to take on this new responsibility. In this situation, too, counselling and education for parenthood may be needed.

Abortion

108. Abortion is chosen as a solution by many women. We estimate 60 000 abortions each year. While resolving the immediate difficulties of the pregnancy, it has its own consequences. Some women would not consider abortion as a possibility.

109. The reasons which may lead a woman to consider abortion as a solution are basically the reasons given for a pregnancy being unwanted. They include the lack of financial resources or financial support; inability to cope emotionally; family size completed or a recent baby; too old; too young to assume parental responsibility; desire to continue studies; desire to avoid a forced marriage; unwillingness to have the baby adopted.⁶⁴ For many women there is more than one reason. Not wanting the child is an important factor, especially among the young and single. It was suggested to us that the pressures on women seeking abortion could be relieved if there were greater acceptance of the child born out of wedlock and if there were better economic support.⁶⁵ Among the measures suggested were increased child endowment, tax deductions to families so women won't have to work; organised home help; better housing and help to establish a home; and maternity leave.⁶⁶ If such changes were made they might assist some women to proceed with the pregnancy, but would probably have less effect on the young and single.

110. There are many pressures on a woman with an unwanted pregnancy, some tending towards abortion and some against it. The family and friends can be involved in this pressure. Women contemplating abortion should have the opportunity to discuss their situation with a counsellor who is aware of all the alternatives and who can help her impartially to consider these.

Adoption

111. Some have suggested that the problem of unwanted pregnancies can be readily overcome by adoption.⁶⁷ In evidence to this Commission for the National Right to Life Association, Dr T. W. Hilgers said:

Unwanted children are really somewhat of a myth. There are so many couples around who would like to adopt.⁶⁸

63. *ibid.*

64. Snyder & Wall, p. 33.

65. Submission 522, Tas. Right to Life Assoc.

66. Submissions 197, ACT Right to Life Assoc.; 585, NSW Right to Life Assoc.

67. Submissions 460, National Council of Women, NSW; 131, SA Right to Life Association.

68. Evidence, p. 255, Dr T. W. Hilgers.

Dr J. J. Billings told us that there are no unwanted children, only unwanting parents.⁶⁹ When it is considered that there may be as many as 60 000 abortions each year, and that the total number of adoptions in Australia in 1973–74 was about 6000, it becomes clear that not many opt for this solution. Among the possible reasons for this are the desire to prevent the family and friends from knowing about the pregnancy and reluctance to go right through the pregnancy and then surrender the child; some may feel unable to do this.⁷⁰

112. As many as 40 000 births may result from unwanted pregnancies each year, including 33 000 children born within marriage and 7000 outside marriage. Not all these births remain unwanted, but it seems that adoption is not chosen as a solution for many unwanted children. There is a tendency for young single girls to keep their babies, and social sanctions may prevent married women with unwanted pregnancies from admitting that they might prefer to give up the child.

113. More children might be made available for adoption if it were more socially acceptable to express unwillingness to rear a child. In some cases financial pressures lead to a decision in favour of adoption. It is desirable that the woman have an opportunity to discuss her situation with an impartial counsellor. Aspects of adoption as an outcome of an unwanted pregnancy are discussed further in Part V.

Keeping the child

114. The consequences to the child and its mother when a child born of an unwanted pregnancy remains unwanted were considered earlier. There are special problems to be faced by the single woman who keeps her child—these are mainly the financial and emotional burdens faced by the lone parent. They should be carefully considered by every woman who plans to keep her child. Parents may be a pressure towards the choice of adoption.

115. The solution chosen by a woman will depend on her own particular circumstances. The young single woman seems more likely to opt for abortion or adoption. Married women with completed families may seek abortion or may keep the child, but seem unlikely to choose adoption.

116. It is particularly important that women be aware of the consequences of each possible alternative. In this connection we commend the pamphlet published by the Council of Social Service of NSW entitled ‘Single, pregnant, what shall I do?’, which sets out clearly the options (see Annexe IV.I). Information of this kind should be available to everyone who has an unwanted pregnancy. We have already made it clear that every woman with an unwanted pregnancy should have access to counselling, to help her to consider these matters.

Pregnancy counselling and pregnancy support services

117. Single women and married women have particular problems in facing an unwanted pregnancy. The problems of the single pregnant girl were discussed in a paper presented to the conference on womens health in a changing society, held in Brisbane in August 1975.⁷¹ These problems include the fear of telling her family, uncertainty about the future, loss of job or problems with schooling, financial worries, change in life style, accommodation, fear of childbirth (because this is usually her first pregnancy), neglect of ante-natal care due to lack of decision and fear, considerations of abortion and adoption, and legal problems.

69. Submission 1146, Dr J. J. Billings.

70. Exhibit 94 (The unwanted pregnancy by June Bell, social worker).

71. M. Allen, Problems of the single pregnant girl (paper presented at IWY conference on ‘Womens health in a changing society’, Brisbane, 25–29 August 1975).

118. The single pregnant girl has to consider all the possibilities open to her, including abortion, adoption and marriage.⁷² Pregnancy counselling services should offer advice and help on all the problems mentioned above, and be equipped and willing to help the pregnant girl to discuss and consider all possibilities for solution of her pregnancy.

119. The married woman with an unwanted pregnancy has other difficulties to face. The services needed for these women include emergency home help services when the woman is sick, community care services such as baby minding, help with shopping or visiting the doctor, and domiciliary services for those women living in areas with inadequate transport. Such services include ante-natal and baby health clinics, visiting community health nurses, social workers and others in the paramedical field.⁷³

A working citizen who is sick can stay at home and receive sick pay or sickness benefit. The sick mother is dependent on her family, neighbours and friends. If she has no family available and no roots formed in her chosen community and cannot afford professional help, she is in a serious dilemma.⁷⁴

120. Accommodation for single pregnant girls is sometimes available in the form of maternity homes. These homes are usually run by various churches, and often offer counselling and education as well as accommodation. An example of this type of home is St Anthony's Home at Croydon in Sydney. This home offers specialist medical services for girls who are not in a hospital fund, part-time physiotherapists for ante-natal exercises, instruction in mothercraft, support after the birth until the girl can find accommodation, social worker advisers, help to obtain further education, and assistance in arranging adoptions. The operation of this home is financed by State Health Commission grants, donations, bequests and annual appeals.⁷⁵

121. School-age girls often have a need for some form of continuing education and provision needs to be made for this. The Commonwealth Department of Social Security offers maternity allowances to all pregnant women. There is no means test on this allowance, and the only condition is that the woman should be a permanent resident of Australia. A pre-birth payment may be made 4 weeks before the expected date of birth, with the balance being paid after the child is born.

122. Single pregnant girls may, in some cases, be eligible for the Department of Social Security's special benefit. This benefit is available during the 12 weeks before the birth, and continues for 6 weeks after the birth. The girl must supply a doctor's certificate stating the estimated date of confinement. There is a means test. The maternity allowance and the special benefit are the only pregnancy support provisions made by the Department of Social Security.

123. A number of agencies offer counselling services which are available to women with unwanted pregnancies. For example, counselling is available from some social workers, psychologists, psychiatrists, marriage guidance and other voluntary agencies and womens health centres. The Family Planning Association offer a service though they have few trained counsellors. There are two specialised services, those offered by Pregnancy Support Services and those offered by abortion clinics and abortion referral agencies. The latter are dealt with in a separate section.

72. *Information for single mothers* (Victorian Council of Social Service, Melbourne, 1975), p. 3.

73. Submission 586, Catholic Womens League NSW.

74. Submission 120, Pregnancy Help, Brisbane.

75. Submission 1141, St Anthony's Home, Croydon.

124. Pregnancy Support Services were formed as a result of what was seen as increasing pressure on pregnant women to seek abortions:

At a time when the SA parliamentary abortion law was being liberalised, people concerned with the nature of the changes themselves sought to provide a positive means of support and assistance to a woman faced with an unplanned pregnancy.⁷⁶

These Pregnancy Support Services exist for the:

. . . mental, physical and economic support of the pregnant girl or woman who may be experiencing some difficulty, in order that her relationships with her unborn child, other family members and society in general may not be embittered, and so that she may not feel pressured to seek an abortion.⁷⁷

Pregnancy Support Services have been established in Sydney (Heartline), Newcastle (Pregnancy Help), Melbourne (Pregnancy Help), Adelaide and Canberra (see Annexe IV.J). We also heard about services available in Tasmania to help women organise adoption and to give material and human support.

125. There are three main groups of pregnant women who use these services. They are unmarried girls with their first pregnancy, deserted wives with their second or third pregnancy, and older married women who find themselves pregnant after their existing families have almost grown up. The bulk of services are provided by telephone counselling. Some office counselling is also provided. The Pregnancy Support Services estimate that single girls comprise 50 to 70 per cent of all calls. Pregnancy Support Services exist only in the major cities and have not adequate financial and staff resources. They use voluntary counsellors, run on voluntary labour and conduct their own training for telephone counsellors. They have some part-time professional assistance. They depend on finance from private organisations and individuals.

126. Pregnancy Support Services generally have some association with the various State divisions of the Right to Life Association.⁷⁸ They are not usually willing to raise the possibility of abortion or to refer women for an abortion.⁷⁹

We have girls who come in and ask for an abortion or for referral for an abortion. If any girls ask for this we usually invite them to come to Pregnancy Help and talk the situation through. If, after the girl has talked, she feels that an abortion is what she wants, we are not prepared to organise that for her. We are an organisation that believes that the unborn child is a very important human being too . . . We feel that giving them this referral is virtually sending the unborn child to its doom. We are not prepared to do that.⁸⁰

127. We consider that the Pregnancy Support Services are a good example of a voluntary effort to help women in distress because of an unwanted pregnancy. Undoubtedly they have helped many in a difficult period and have worked hard and with little financial assistance. We regret, however, that we cannot unreservedly support the Services because they exclude abortion as a possible outcome of an unwanted pregnancy. We think that all options should be considered and discussed, and that abortion will be appropriate in some cases. Women seeking abortion may find their

76. Submission 129, Birthline, South Australia.

77. Submission 771, Caroline Chisholm Society's Pregnancy Support Service.

78. e.g. see Submissions 585, NSW Right to Life Assoc.; 129, Birthline, South Australia.

79. Replies to questionnaire, Commission file S208: 'What is the policy of your organisation with regard to requests for termination of pregnancy?'

Sydney: 'We would never give a referral for termination of pregnancy'.

Newcastle: 'Outside the terms of reference of our organisation'.

Brisbane: 'We are not an abortion referral agency'.

Adelaide: 'Not done'.

Canberra: 'We advise the client to consult her own doctor'.

80. Evidence, p. 1633, M. Allen & N. McNamara.

way to other services, or they may not. We appreciate the convictions of those involved in Pregnancy Support Services; nevertheless it is our view that the point of first contact should outline all possible solutions and refer to other agencies as appropriate.

128. The policy of abortion clinics and referral agencies is that all options are discussed when a woman is counselled, and, in a few cases, the woman decides not to proceed. For many women, this is the only opportunity they have for counselling.

129. It might in principle be preferable to provide an independent counselling service for pregnant women. We think that there is a need for a more general pregnancy support and counselling service which would combine the services of the existing Pregnancy Support Services and abortion counselling services, but which would not be directly associated with either. The role of such a service should be to assist women with an unwanted pregnancy to decide what to do. Associated functions could be the provision of information about abortion and adoption procedures, social security and social services, pregnancy, childbirth, lactation, contraception. Such services could possibly be provided in conjunction with hospital or family planning clinics, or by community health services. They should not displace counselling services now available at abortion clinics. Many women might receive no counselling at all if it were not available at the clinics.

4. Abortion

Introduction

1. Our terms of reference ask us to report on:

(e) the adequacy and effectiveness of existing medico-legal determinations in relation to termination of pregnancy, the incidence of such terminations, the factors influencing their occurrence, the adequacy of medical training in an evaluation of methods of termination, consultative rights of the family or other persons concerned and the adequacy and effectiveness of pregnancy support services.

We have also been asked to consider:

(d) the social, economic, psychological and medical pressures on women in determining whether to proceed with unplanned or unwanted pregnancies, having regard to:

(iii) . . . the social, psychological and medical results of termination of, or and failure to terminate such pregnancies.

This chapter covers the legal, social and moral issues related to abortion, the incidence of abortion, attitudes to abortion, the consequences of abortion and abortion services.

Legal and moral issues

The law and abortion

2. Australia is one of many countries in which the reform of abortion law has been a major topic of public interest in recent years.
3. Abortion issues have been hotly debated in the UK since the introduction and passage of the Abortion Act 1967, and the Report of the Committee on the Working of the Abortion Act in 1974.¹ A parliamentary Select Committee reported on the matter in July 1976.
4. In the US the Supreme Court decisions of January 1973² have been followed by intense debate, by legislation in some states and by further decisions of the Supreme Court.
5. New Zealand set up a Royal Commission on Contraception, Sterilisation and Abortion which is due to report in 1977 and there has been an important decision of the Supreme Court dealing with abortion.³
6. France, Germany, Sweden, Denmark, Italy and Austria have all had important legislation or judicial decisions in recent years.
7. In Australia, legislation in South Australia (1970) and in the Northern Territory (1974) and judicial decisions in Victoria (1969) and New South Wales (1972) have liberalised the law of abortion. An unsuccessful attempt to amend the law of the ACT led to the setting up of this Commission.⁴ During the term of this Commission a Bill was introduced unsuccessfully into the NSW Legislative Assembly to restrict the availability of abortion.

1. *Report of the Committee on the Working of the Abortion Act*, vol. 1 (HMSO, London, 1974), Cmnd. 5579, hereinafter referred to as the Lane report.

2. *Roe v. Wade* 93 S Ct 705 (1973); *Doe v. Bolton* 93 S Ct 739 (1973).

3. *R v. Woolnough* (see Annexe IV.K).

4. For details see RCHR, *Interim report* (AGPS, Canberra, 1976), pp. 4-6.

8. 'Abortion' in the following discussion means 'termination of pregnancy before the foetus has attained viability, i.e. become capable of independent extra-uterine life'.⁵

Abortion law in England

9. The law concerning abortion in Australia has its roots in British law. Prior to 1803 abortion was dealt with by ecclesiastical courts with punishment in the form of penances. In that year section 1 of an Act known as Lord Ellenborough's Act⁶ made it a capital offence for any person unlawfully to administer any noxious and destructive substance or thing with intent to procure the miscarriage of a woman 'quick' with child. The law was amended in 1837 and in 1861 by the Offences against the Person Act. Section 58 of this Act provided that:

Every woman being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony.⁷

10. This Act continued to be law until 1967 when the United Kingdom Abortion Act was passed. Prior to this, however, the Infant Life (Preservation) Act 1929 created the offence of child destruction as follows:

Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act, causes a child to die before it has an existence independent of its mother . . .

Provided that no person shall be found guilty . . . unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.⁸

11. In 1938, in the case of *R. v. Bourne*, this concept of preservation of the life of the mother was adopted by Mr Justice McNaughton in determining the circumstances in which an abortion could be said to be unlawful:

. . . if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the woman.⁹

12. The meaning of 'unlawful' was further interpreted by Ashworth J. in *R. v. Newton and Stungo*¹⁰; in his view acts in good faith for the preservation of physical or mental health were not unlawful. The ambiguity of the law rested on the fact that there was no clear definition of what constituted an 'unlawful' administration of drugs or use of instruments to procure a miscarriage. This meant that the law was dependent upon judicial interpretation and thus uncertain in its application. Nevertheless, by 1967, substantial numbers of abortions were being performed under the National Health Scheme by doctors using the McNaughton interpretation of the law.¹¹

5. *Spontaneous and induced abortion*, WHO Technical Report Series, no. 461 (WHO, Geneva, 1970), p. 6.

6. The Miscarriage of Women Act 1803, 43 Geo. III, c. 58.

7. 24 & 25 Vic., c.100, section 58.

8. Section 1 (1).

9. [1938] 3 All ER 619.

10. [1958] Crim. LR 469.

11. Lane report, p. 11.

13. The Abortion Act 1967 laid down grounds and conditions for the legal termination of pregnancy as follows:

Medical termination of pregnancy

- (1) Subject to the provisions of this section a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—
 - (a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or
 - (b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
- (2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.
- (3) . . . any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health . . . or in a place for the time being approved.

The Act also provides for the termination of pregnancy without the need for two doctors' opinions or an approved place of operation, if the termination is immediately necessary to save the life of the mother or prevent grave permanent injury to the physical or mental health of the pregnant woman.¹²

14. The legality of an abortion therefore depends upon two doctors forming the opinion in good faith either that there is a risk to the life of the woman or of injury to her physical or mental health greater than if the pregnancy were terminated, or that there is a substantial risk of serious handicap to the child.

15. Although the passage of the 1967 Act tended to stabilise the legal situation in Britain, there has been a great deal of public and political debate. In 1971 a Committee was established to inquire into the working of the Abortion Act. The Committee sat for 3 years and published its report in 1974. It recommended there be no change in the wording of the Act laying down the criteria for abortion, and that the criteria be applied and the risks weighed in each individual case.¹³ Some changes were recommended to authorise abortion within the criteria up to the 24th week of pregnancy; after that date efforts would have to be made to preserve the life of the child.¹⁴ These recommendations have not yet been implemented.

16. James White, MP, put forward a proposed Abortion (Amendment) Bill in February of 1975. The Bill proposed to restrict the availability of medical termination of pregnancy by placing conditions on the qualifications of the doctors allowed to recommend termination; by providing a residency requirement; and by restricting abortion to women whose pregnancy was less than 20 weeks unless a consultant was reasonably satisfied that the child would be born with a major disability, whether physical or mental.

17. The Bill was not passed but led to the setting up of a Parliamentary Select Committee on Abortion. In July 1976 the Committee recommended that the Abortion Act be amended to restrict abortions to an upper limit of 20 weeks except where the

12. Section 1 (4).

13. Lane report, vol. I, p. 71.

14. *ibid.*, paras 280, 281.

mother's life or health was at stake or where the child might be born with major disabilities. It also recommended that heavier penalties be imposed for illegal abortions and that police have a right of access at law to the records of clinics performing abortions. As yet these recommendations have not been made law.

Abortion law in Australia

18. In Australia, except for South Australia and the Northern Territory, the statute law is still based on the British Offences against the Person Act of 1861. The lawfulness of abortion is based on the interpretation of the term 'unlawful' as used in the legislation. Abortion laws in Australia fall into three categories:

- (a) 'Common law' States and Territories (NSW, Victoria and the ACT) in which the law, basically the English law before the 1967 Act, has been liberally interpreted by judicial decision.
- (b) Code States (Queensland, Western Australia, Tasmania) in which the English law is qualified by a statutory exemption and where there has been no judicial liberalisation of the law.
- (c) South Australia and the Northern Territory which have liberalised abortion laws by legislation similar to the English Act of 1967.

New South Wales

19. Abortion in New South Wales is regulated by sections 82, 83 and 84 of the New South Wales Crimes Act, 1900.

Section 82

Whosoever, being a woman with child, unlawfully administers to herself any drug or noxious thing, or unlawfully uses any instrument or other means, with intent in any such case to procure her miscarriage, shall be liable to penal servitude for 10 years.

Section 83

Whosoever unlawfully administers to or causes to be taken by, any woman, whether with child or not, any drug or noxious thing, or unlawfully uses any instrument or other means, with intent in any such case to procure her miscarriage, shall be liable to penal servitude of 10 years.

Section 84

Whosoever unlawfully supplies or procures any drug or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used with intent to procure the miscarriage of any woman, whether with child or not, shall be liable to penal servitude for 5 years.

The meaning of 'unlawful' in the New South Wales Crimes Act was examined in 1972 by Mr Justice Levine in the case of *R. v. Wald and Others* as follows:

The accused must have had an honest belief on reasonable grounds that what they did was necessary to preserve the women involved from serious danger to their life, or physical or mental health, which the continuance of the pregnancy would entail, not merely the normal dangers of pregnancy and childbirth, and that in the circumstances the danger of the operation was not out of proportion to the danger intended to be averted. The Crown of course bears the onus of establishing that the operations were unlawful.¹⁵

20. Levine J. also held that as a matter of law it was not necessary that there be two doctors' opinions or that the abortion be performed in a public hospital. On the question of what amounted to danger to mental health, he said:

Of course in determining that question with regard to mental health, it is proper for you, the jury, to consider whether the danger to the mental health arose from not only mental disease, or disease of the mind, but from the effects of economic or social stresses that may be pertaining at the time.

15. (1972) 3 DCR 25.

21. There have been no successful prosecutions for illegal abortion in New South Wales since the Levine ruling in 1972. In that year twenty-three charges made against a doctor of unlawfully using an instrument to procure a miscarriage were dropped when the jury failed to reach a verdict; in 1976 charges against a doctor and a nurse at the Liverpool Womens Community Health Centre were dropped when the Attorney-General ruled a 'no bill'.

22. In 1974 the then Attorney-General of NSW issued a statement of the law as follows:

What the law does provide is that:

an abortion performed by an unqualified person, whatever be the circumstances, is punishable by penal servitude for 10 years;

there is no offence where a duly qualified medical practitioner terminates a pregnancy in the bona fide belief that the continuation of the pregnancy places the woman's life or health in greater jeopardy than its termination;

where no such bona fide belief exists, the medical practitioner is also liable to penal servitude for 10 years.

23. During the life of this Commission a private member's Bill was introduced into the NSW Legislative Assembly to impose more stringent regulation on abortion. The aim of the Bill was stated by its sponsor as follows:

To protect the inviolability of all human life and to ensure that the civil rights of foetal life are guaranteed and protected by the state.¹⁶

The Bill provided that for abortion to be lawful it must be carried out in a public hospital or a registered private hospital; two medical practitioners must certify on oath that the abortion is necessary to prevent the death of the mother; the doctor must be able to prove he acted in good faith for that purpose; and the abortion must be registered.

24. In introducing the Bill the sponsor, Mr K. Harrold, referred to various estimates of the number of abortions performed in NSW, to the easy availability of abortion in NSW and to 'open touting for abortion business'. He claimed that the law is not being enforced and that abortion on demand is legally sanctioned. Debates on the Bill show that strong views are held on each side of the issue. The Bill lapsed.

Victoria

25. In Victoria abortion is regulated by sections 65 and 66 of the *Crimes Act 1958*:

Section 65

Whosoever being a woman with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or unlawfully uses any instrument or other means, and whosoever with intent to procure the miscarriage of any woman, whether she is or is not with child, unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means with like intent shall be guilty of a felony and shall be liable to imprisonment for a term of not more than 15 years.

Section 66

Whosoever unlawfully supplies or procures any poison or other noxious thing or any instrument or thing whatsoever, knowing the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether with child or not, shall be guilty of a misdemeanour and shall be liable to imprisonment for a term of not more than 3 years.

16. The Infant Life Preservation Bill was given a first reading on 2 March 1976 (NSW Parliament, Hansard, 3793-807). The Bill was introduced by Mr K. Harrold (Gordon).

26. As in New South Wales, the statute, which has been largely taken from the UK Offences against the Person Act 1861, hinges upon the judicial interpretation of the term 'unlawfully'. In 1969 Mr Justice Menhennitt was called upon to interpret the meaning of 'unlawful' in section 65:

Having regard to the deliberate and repeated use of the word 'unlawfully' in section 65 and the nature of the offence created and the history thereof, and in the light of the authorities and views of learned authors to which I have referred, it appears to me that necessity (that is, the doctrine of necessity to which I have referred before) is the appropriate principle to apply to determine whether a therapeutic abortion is lawful or unlawful within the meaning of section 65. That aspect of the element of necessity in relation to prevention of a felony or arrest of a felon or self-defence is that the accused should honestly believe on reasonable grounds that what he did was necessary. In principle it appears to me that the same concepts should apply to the element of necessity in relation to unlawfulness in section 65 of the *Crimes Act 1958*.¹⁷

27. He went on to state the conditions under which an abortion could be performed 'lawfully':

For the use of an instrument with intent to procure a miscarriage to be lawful, the accused must have honestly believed on reasonable grounds that the act done by him was:

- (a) necessary to preserve a woman from the serious danger to her life or her physical or mental health, not being merely the normal dangers of pregnancy and childbirth, which the continuance of the pregnancy would entail; and
- (b) in the circumstances not out of proportion to the danger to be averted.

28. It is unclear from *R. v. Davidson*, however, whether a Victorian court would examine the social and economic conditions or environment of the woman in determining danger to her life or physical and mental health as has been done in New South Wales.

Australian Capital Territory

29. Sections 82, 83 and 84 of the New South Wales Crimes Act are applicable to the Australian Capital Territory.¹⁸ Although no decisions have been made concerning the application of *R. v. Wald* to the ACT it can be assumed that it would be applicable. The history and text of the Medical Practice Clarification Bill 1973 are set out in our *Interim report*.¹⁹ The Bill would have made abortion lawful up to 12 weeks pregnancy if adequate advice had been given. It was the subject of heated debate and led to the setting up of this Commission.

30. A Draft Criminal Code was proposed in the Report of the Working Party on Territorial Criminal Law published by the Attorney-General's Department in June 1975. Section 25 of the Draft Code basically re-enacted the provisions of sections 82 and 83 of the New South Wales Crimes Act without any further clarification of the term 'unlawfully'. Some changes were proposed by the Working Party but were not accepted by the Attorney-General.

Queensland

31. In Queensland the provisions dealing with abortion are contained in sections 224, 225, 226 and 282 of the Queensland Criminal Code:

Section 224

Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious

17. *R v. Davidson* [1969] VR 667.

18. Under section 45 of the *Pharmacy Ordinance 1933-1975* a chemist will be exempt from a charge under section 84 of the Crimes Act if he supplied the substance or thing referred to in the section on the prescription of a registered medical practitioner.

19. *Interim report*, pp. 4-5, Annex B, pp. 28-30.

thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment with hard labour for 14 years.

Section 225

Any woman who with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment with hard labour for 7 years.

Section 226

Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure a miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment with hard labour for 7 years.

32. A defence exists to the offence proscribed in section 224 in the form of section 282 of the Code:

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon any unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

The defence contained in section 282 is basically a legislative formulation of the ruling in *R v. Bourne*. What interpretation would be given to the expression 'for the preservation of the mother's life' and what would be considered 'reasonable having regard to the patient's state at the time and all the circumstances of the case' has yet to be seen, however. In 1955 in *R. v. Ross* the Queensland Court of Criminal Appeal observed that:

The words 'preservation' and 'life' do not bear any technical meaning, and although in *R. v. Bourne* . . . the meaning of similar words was explained to the jury, it is my opinion that no such explanation is necessary in this case (per Mansfield S.P.J.).²⁰

33. The absence of any judicial ruling on this matter means that it would be for the jury to decide the 'reasonableness' of the operation involved. It is uncertain whether Queensland would follow the post-Bourne decisions which have expanded the meaning given to the term to 'preserve the mother's life'.

Western Australia

34. Western Australia has legislated against abortion in sections 199, 200 and 201 of the Western Australian Criminal Code 1913:

Section 199

Any person who with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind or uses any other means whatsoever is guilty of a crime and is liable to imprisonment with hard labour for 14 years.

Section 200

Any woman who with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind or uses any other means whatsoever or permits any such thing or means to be administered or used to her, is guilty of a crime and is liable to imprisonment with hard labour for 7 years.

20. [1955] St R Qd 48.

Section 201

Any person who supplies to or procures for any person anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment with hard labour for 3 years.

35. As in Queensland, a defence exists to section 199 in terms of the provisions of section 259:

A person is not criminally responsible for performing, in good faith and with reasonable care and skill, a surgical operation upon any person for his benefit or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

36. Section 259 is open to the same interpretation as section 282 of the Queensland Criminal Code. It offers no real guidelines on what constitutes 'the circumstances of the case' or 'the preservation of the mother's life'. As yet there have been no judicial interpretations. It is not clear, therefore, whether Western Australia would follow the interpretations of *R. v. Davidson* and *R. v. Wald*.

Tasmania

37. The Tasmanian *Criminal Code Act* 1924 provides in sections 134 and 135 for the offence of administering poison (or other noxious thing) to procure an abortion or aiding an intended abortion:

Section 134

Any woman who, being pregnant, unlawfully administers to herself, with intent to procure her own miscarriage, any poison or other noxious thing or with such intent unlawfully uses any instrument or other means whatsoever is guilty of a crime.

Any person who with intent to procure the miscarriage of a woman, whether she be pregnant or not, unlawfully administers to her or causes her to take any poison or other noxious thing or with such intent unlawfully uses any instrument or other means whatsoever is guilty of a crime.

Section 135

Any person who unlawfully supplies to or procures for any other person anything whatever knowing that it is intended to be unlawfully used with intent to procure the miscarriage of a woman, whether she is or is not pregnant, is guilty of a crime.

38. There are two sections of the Tasmanian Criminal Code which could possibly provide defences to the performance of an abortion. Section 51 (1) makes it lawful for a person to 'perform in good faith and with reasonable skill a surgical operation upon another person, with his consent and for his benefit, if the performance of such an operation is reasonable, having regard to all the circumstances'. This section is similar to section 259 of the Western Australian Criminal Code and section 282 of the Queensland Criminal Code except that it makes no special reference to the clause contained in the other two—'or upon an unborn child for the preservation of the mother's life'. There have been no judicial decisions to interpret whether the word 'reasonable' refers to acts reasonable within the circumstances or to a reasonable medical procedure.

39. Section 165 of the Tasmanian Criminal Code refers to destruction of a child 'who has not become a human being' and subsection (2) of that section provides that a defence exists if the person 'by any means employed in good faith for the preservation of its mother's life causes the death of such a child before or during its birth'. If section 51 (1) is read therefore in conjunction with section 165 (2) the result is that abortion may be lawful in Tasmania only on the same conditions as expressed in the

Western Australian and Queensland statutes. The uncertainty of judicial interpretation of the statute law in Tasmania is probably even greater than in Queensland and Western Australia, however, because of the meaning of 'child destruction' clauses and their relationship to abortion.

South Australia

40. In South Australia and the Northern Territory legislation has been passed which allows for abortion to be lawful in certain situations. This has clarified considerably the application of the various judicial interpretations of 'unlawfully'. Both reforms have been based on the UK Abortion Act of 1967 and as such do not go so far as the NSW case of *R. v. Wald*; that decision does not require two doctors' opinions or performance of the operation in a hospital.

41. In South Australia sections 81 and 82 of the South Australian Criminal Law Consolidation Act, which are similar in form to the basic legislation in all the other States (i.e. based on the UK Offences against the Person Act 1861), have not been repealed but an additional section, section 82A, has been added to the legislation. This allows for an abortion to be lawful if it is performed by a legally qualified medical practitioner, acting in good faith and with the opinion of a second doctor to terminate a woman's pregnancy if:

- (a) the continuance of the pregnancy would involve greater risk to life or mental or physical health of the woman; or if there was substantial risk that the child will be born with such mental or physical abnormalities as to be seriously handicapped, and treatment is carried out in a prescribed hospital;
- (b) the conditions as to the second opinion and the prescribed hospital may be waived if the doctor is of the opinion, formed in good faith, that termination is immediately necessary to save the life of the woman, or prevent grave injury to her mental or physical health.

42. In forming their opinion the doctors may take into account the 'pregnant woman's actual or reasonably foreseeable environment'. They cannot act under the section if the woman is over 28 weeks pregnant or if she has not been resident in South Australia for a period of 2 months prior to the termination.

Northern Territory

43. In the Northern Territory the legislative changes have been similar. Sections 78 and 79 of the *Criminal Law Consolidation Act and Ordinance* 1876–1974, which correspond to sections 81 and 82 in South Australia, have not been repealed but an addition has been made to the law in the form of section 79A. Under section 79A (3), a doctor, who must be a gynaecologist or obstetrician, and acting on two opinions formed in good faith, may terminate the pregnancy of a woman who is less than 14 weeks pregnant if he/she has reasonable cause to believe that to continue the pregnancy would entail greater risk to the life or physical or mental health of the woman, or if there is a substantial risk that the child would suffer from such physical or mental abnormalities as to be seriously handicapped.

44. Any medical practitioner can perform an abortion on a woman up to 23 weeks pregnant if he/she is of the opinion, formed in good faith, that the termination is immediately necessary to prevent grave injury to her mental or physical health. There are no limitations if the operation is carried out in good faith, solely to preserve the life of the mother. The Act requires the consent of the woman and the consent of 'those responsible in law' if the woman is under the age of 16 or otherwise incapable of giving consent.

Summary

45. As a result of the Levine ruling in 1972 (*R. v. Wald*), New South Wales has probably the most 'liberal' abortion law in Australia. There is no requirement for a second medical opinion nor is there a restriction to a hospital or an authorised place. The doctor may take into account the physical and mental health of the woman and the effects of social stress. The abortion services now available in NSW at privately run clinics have been established since the ruling. A similar position applies in Victoria; while there has been no decision in the ACT it is assumed that the law is similar to that of NSW.

46. There is doubt whether the decisions in *R. v. Davidson* and *R. v. Wald* would be followed in Queensland, Western Australia and Tasmania.²¹ It is arguable that because there is express legislative provision in these States for abortion to be lawful, if done to save the life of the mother, a wider interpretation of the conditions for lawful abortion would not be possible. The law remains uncertain due to the fact that there have been no real guidelines laid down to interpret what is meant by the phrase 'to preserve the life of the mother' or to ascertain in what 'circumstance' such an operation would be 'reasonable'.

47. In South Australian and the Northern Territory precise guidelines have been laid down to determine the conditions which will make an abortion lawful. The sections, however, corresponding to the provisions in the Crimes Act States have not been repealed and it could possibly be argued that these statutes are open to a still wider interpretation. The reformed laws impose greater restrictions than those applied in the New South Wales decision of *R. v. Wald*.

48. Problems may also arise at law in two other areas apart from the recognised case of abortion. These are the rise of methods of birth control described as 'abortifacients' and those laws which regulate the crime of what is referred to as 'child destruction' or the destruction of a foetus 'capable of being born alive'. These are considered later.

Other countries

49. At Annexe IV.K. we set out some information about abortion law in the United States and New Zealand. New Zealand law is of particular interest in view of a recent decision following the *R. v. Bourne* line of cases.

Criticisms of the law

50. The proponents of abortion law reform generally seek to go further than any of the legislative provisions or judicial rulings now in force in Australia. In their view there should be no legal regulation or prohibition of abortion unless it is necessary to ensure proper medical practice. The opponents of reform argue that the abortion laws are already too liberal in some places and that abortion should be prohibited altogether unless to preserve the mother's life. The main objections to the present laws by those seeking reform are:

- (a) that the law causes more harm than it prevents by driving abortion underground;
- (b) that the law is ineffective to prevent abortion, is disregarded and is impossible to apply;
- (c) that the law operates to deny abortion to many women who genuinely need it;
- (d) that the law is uncertain;

21. See D. Chappell & P. R. Wilson, 'Public attitudes to the reform of the laws relative to abortion and homosexuals', 42 ALJ 120.

- (e) that the law is not uniform and that women in different States have unequal access to abortion facilities.

51. The material presented in the section on abortion services in this chapter shows that restrictive laws have not in fact prevented the performance of abortions. What they do is to impede the scrutiny of abortion services by driving them underground. This leaves the patient without protection or legal remedy against malpractice.

52. The uncertainty of the law in some States may cause problems for the medical profession and for patients. There is still some covertness and therefore a lack of public scrutiny of procedure or practice. Doctors may overcharge, use unsafe methods, impose their moral views on the patient, or require a second opinion at extra expense when this is not necessary on medical grounds. All these things can occur when there is doubt about the law. Practitioners run a risk of possible police action and this hampers the extension of and advertising of services. Uncertainty may also be a factor leading to delay in the request for an abortion until a time when the operation is more risky:

. . . underprivileged women are much more exposed to traumatic experiences and to dangerous delays when seeking an abortion than middle-class women who have both the sophistication and the finance to be selective.²²

The lack of facilities and of information about facilities is another factor leading to delay, to unequal access to services and to variable quality of services.

53. It was considerations like these which led the Canadian Royal Commission on the Status of Women to conclude that:

A law that has more bad effects than good ones is a bad law . . . As long as it exists in its present form thousands of women will break it.²³

and the Poverty Commission to express the following view:

It is hypocritical that a society can act to deny abortion to women quite capable of making a decision about an unwanted pregnancy, while at the same time claiming concern about physical and mental health, quality of life, poverty and human rights. Modern abortion techniques have increased the safety of the procedure and we believe it should be freely available, particularly while education, counselling and reliable contraceptive measures are not sufficiently available to prevent unwanted pregnancy.

This is especially important for those who, for a variety of possible reasons, have been unable to plan conception as they may choose and decide to terminate a pregnancy. Poor people are included in this category largely because they often cannot meet the cost involved, or do not know where to seek family planning advice.²⁴

54. On the other hand many consider that the law is already liberal enough; to extend it further would lead to an increased number of abortions. Some believe that the law strikes a reasonable balance between differing views on the complex legal and moral issues involved.

Policy of abortion law

55. A further criticism which could be levelled at the law is that it appears to have no clear policy. Something like 60 000 abortions are performed annually in Australia. Since there have been almost no successful prosecutions for illegal abortions in recent

22. Submission 1056, Department for Community Welfare, WA.

23. *Report of Royal Commission on the Status of Women in Canada* (Ottawa, 1970), para. 240. They recommend that abortion on request be legal up to 12 weeks of pregnancy.

24. *Social/medical aspects of poverty in Australia*, p. 149.

years, it must be presumed either that each of these 60 000 cases comes within the appropriate legal exemption, or that it is impossible for the authorities to supervise and enforce such an exemption,²⁵ or that the authorities are content to allow abortions to be performed whether or not they conform with the exemption.

56. In our view the current situation in States such as NSW and Victoria presents many difficulties both for medical and legal practice. The legality or illegality of an abortion depends not on objectively established criteria but on the surrounding circumstances of the case, on the subjective view taken of those circumstances by the doctor at the time and on the jury's opinion of both those matters formed at a later date. The doctor's judgment of the situation is liable to be tested by others at a later date even if the woman is perfectly satisfied about the matter. When carried to its limit the law can be seen to be absurd: a woman may be able to satisfy a medical practitioner that she has acceptable grounds for an abortion under the law of a particular State, but if the doctor performing the abortion acts without inquiring into those grounds, then strictly speaking he may have committed an offence. To perform an abortion lawfully the doctor must not only exercise proper professional care and skill; he or she must also consider all aspects of the physical and mental health of the woman and, in some cases, her social circumstances as well; these must be weighed in the balance against the risks of termination. In South Australia two doctors must form an opinion about the matter.

57. This makes the offence of performing an abortion different from other offences and leaves both doctors and lawyers in an unenviable position. The extreme difficulty of leaving such issues to be dealt with by the legal system was referred to in a recent New Zealand decision in which Richmond J. made the following comments:

The function impliedly entrusted to the Courts by section 183 is not to say who is right and who is wrong as between the extreme views held by different sections of the community as regards this highly controversial subject. Rather the Courts have to do their best to draw a line at a point where the procuring of a miscarriage ceases to be merely a matter of debate, from a religious, moral or ethical point of view, and becomes activity of a kind which warrants its designation as criminal.²⁶

58. To answer that question adequately it is necessary to examine the underlying purpose of abortion laws, and the moral and social issues involved, and to ask what public interest is protected by laws outlawing abortion. Do they aim to protect the health and safety of the mother and to ensure that she is not subject to undue risk of physical or mental injury? Or do they aim to preserve the life of the unborn child except in certain defined circumstances when other interests displace those of the foetus?

Protection of the pregnant woman

59. If the purpose of abortion law were to protect the pregnant woman's health and safety a few clearly defined issues would need consideration. First, the performance of abortion would be restricted to qualified medical practitioners. We consider it proper to prohibit unqualified persons from performing abortions; the exercise of professional skill and judgment is required. We have not in this report considered whether trained paramedical personnel could perform abortions; this is an issue which may arise in the future. Would any other legal regulation of abortion be needed?

60. It is sometimes argued that abortion should be controlled by strict criteria because of the risks entailed. Our studies do not support the contention of risk, at least in the early stages of abortion. Our research shows that, when carried out by a medical

25. J. Finnis (1970) 3 Adelaide L. Rev. 431, quotes C. B. Goodhart on the English Act.

26. *R. v. Woolnough*, NZ C of A 1976.

practitioner under appropriate conditions, early abortion is not risky and presents little danger to physical health. It is likely to be even less risky than childbirth. The psychological consequences of abortion (or of refusal of abortion) are more difficult to determine.

61. The risks of abortion are not, in our view, a sufficient reason for imposing legal sanctions on abortion. They do suggest a need for good quality medical care and proper counselling. There may also be a case for regulation to ensure that the places where abortions can be performed meet satisfactory standards, but it does not follow that special regulations are needed which apply only to abortion facilities. On the face of it, however, there seems to be no special case for the intervention of the criminal law to ensure that proper medical safeguards apply. The standards of medical practice should be sufficient to ensure that the patient's health and safety are taken care of, as in the case of any other surgical procedure, provided that the procedure is open to public scrutiny and is not performed clandestinely. Health and medical authorities have an interest in maintaining and improving the standards of health and medical care but the criminal law is not usually resorted to for this purpose.

62. The main reason why it is thought that legal regulation is necessary is that abortions have been performed clandestinely and have attracted malpractice and corruption. The question of regulation cannot be finally determined before consideration of the circumstances in which abortion is authorised and performed openly and under public and professional scrutiny. We consider later whether there needs to be regulation or licensing of abortion services.

Protection of the foetus

63. If there is justification for making abortion a criminal offence it can only arise from a general public concern to protect the life of the foetus. Should the law protect that life by outlawing abortion? Human life has from time immemorial been protected by laws prohibiting and punishing murder, manslaughter and attempted suicide.²⁷ Should the life of the foetus which commences at conception be considered as of the same absolute value as other human life or are there defined circumstances in which its destruction can be justified in legal or moral terms?²⁸

64. The opponents of abortion consider that abortion cannot be justified except to save the mother's life. They uphold in absolute terms the sanctity of human life from the moment of conception. For them abortion is the taking of life; it offends against religion and morality and involves such a disregard for human life that it should be prohibited.²⁹ At the other extreme are those who consider that abortion should be completely free of legal regulation and that it is essentially a decision for the woman and her doctor.³⁰ There is also support for an intermediate position which would allow

27. Modern law reforms have in some cases abolished the offence of attempted suicide.

28. For a discussion of these issues see Glanville Williams, *The sanctity of life and the criminal law* (Faber and Faber, London, 1958).

29. The Right to Life Associations (RTLAs) Submissions 131, SA; 162, National; 197, ACT; 522, Tas; 585, NSW; see also Submissions 111, Mrs J. Johnstone; 130, Mr T. McLaughlin; 135, Mrs W. Egan; C136, confidential; 158, SA Lutheran Church of Australia—Social Questions Commission; 180, Australian Council of Catholic Women; 187, Mrs B. Layton; 235, A. J. Staunton; 257, Mr N. K. Madsen; 283, Mr J. Marrow; 330, Mr John Barraclough; 332, name withheld; C345, confidential; 369, Miss Maureen Walsh; 374, Miss Clare Gleeson; 429, Dr D. Hollway; 446, Drs J. Quoyale and B. Kearney; 747, Dr K. Churches; 994, Human Life Research Foundation; 1047, UK Society for Protection of Unborn Children; 1061, Mrs C. Marne; 1146, Dr J. J. Billings; 1170, Reformed Church of Launceston.

30. Submissions 182, Mrs P. Elvin; 514, Mr T. W. Goulden; 535, Yvonne Foster, Humanist Society; 556, J. Cole & F. Beighton; 732, G. & C. Somssich; 754, Kim McLellan, an abortion is preferable to an unwanted child; 794, K. W. Johanson; 995, The Congregational Union of Australia; Evidence, p. 394, B. Gilling.

abortion in certain defined situations.³¹ A growing number of people consider that social circumstances may justify abortion; that it is not a matter for the criminal law at all.

65. The diversity of views about abortion suggests that the religious and moral objections to abortion do not represent a consensus of opinion. Our review of attitudes confirms this. It is important to ask whether the life of the foetus should be protected by the criminal law. Can it be distinguished from other human life? Can society condone the destruction of the foetus without at the same time diminishing the value of human life? These are important moral issues which should not be ignored in any discussion of abortion.

The foetus and human development

66. We had many submissions about the foetus or unborn child, its development from conception to birth, its humanity, its viability, and about the social, moral, religious and legal issues involved in its destruction by abortion. A great deal of material was put before us. We were also shown a film about the foetus and its movements in the early stages of development.³²

67. We were assisted in our understanding of these matters by a large body of evidence presented to us by the National and State Right to Life Associations.

Definitions

The foetus has been defined in a number of ways.

- (a) The Shorter Oxford English Dictionary definition of 'foetus' includes: 'the young of viviparous animals in the womb when fully developed'.
- (b) Black's Medical Dictionary, 30th edn, 1974: 'foetus or embryo is the name given to the child while still within the womb'.
- (c) The Lane report: 'foetus: the child prior to birth'.³³
- (d) The Peel report: 'foetus: the human embryo from conception to delivery'.³⁴
- (e) The report prepared for us on the consequences of abortion (see Annexe IV.P) defines foetus as the potential infant growing in the uterus. Before 6 weeks it is a 'zygote' for the first 10 days; then an 'embryo'.

68. Strictly speaking the term 'foetus' refers to the embryo when fully formed at about 8 weeks after conception. The Peel report has applied to the term 'foetus' a meaning wider than that usually ascribed to it in medical terminology. We think that is a convenient definition in a general discussion of social issues in a non-technical context and, for this chapter, therefore we use the term foetus to mean 'the human embryo from conception to delivery'.

Foetal development

69. From the material available to us we have prepared the following timetable of foetal development as an aid to considering some of the arguments about abortion

31. e.g. Exhibit 194 (Anglican Diocese of Sydney: serious threat to mental or physical health); Submissions 112, Australian Council RCOG; 273, Mrs F. D'Souza.

32. *The first days of life* distributed by Pro-life Inc. was shown to us by Dr G. J. Gartlan, obstetrician & gynaecologist, of the RTLA Tasmania, see evidence pp. 2269-71.

33. Lane report, vol. I, p. 267.

34. Dept of Health and Social Security, *Report of the Advisory Group on the Use of Foetuses and Foetal Material for Research* (HMSO, London, 1972), hereinafter referred to as the Peel report.

and issues such as viability.³⁵ Publications such as *The everyday miracle* provide illustrations for some of the stages described. Other descriptions of foetal development are at Annexe IV.L.

Timetable

70. The days and weeks are measured from fertilisation.

Week 1 day 1 Ovulation: 14 days before menstruation the ovum (or female gamete) is released from the follicle in the ovary and passes into the fallopian tube. Fertilisation occurs in the fallopian tube, probably within 24 hours of ovulation. (Intercourse may be one or more days before ovulation or shortly after.) The spermatozoon (or male gamete) penetrates the ovum and fuses with it to form the zygote (or fertilised ovum). The 23 single chromosomes in each gamete fuse to form 23 pairs of chromosomes which determine the sex genes and physical make-up of the new entity which now has its own characteristics. The single cell of the zygote divides into two, then into four. Further divisions occur as the zygote travels down the fallopian tube towards the uterus (or womb).

Week 1 days 4–5 The zygote enters the uterus; by the process of cell division and differentiation it has become a sphere of cells with identifiable layers or regions, and at this stage it is called the blastocyst (or blastula).

Week 2 days 7–14 Implantation of the blastocyst in the wall of the uterus occurs after 7–10 days. The outer layer of the blastocyst submerges in the uterine wall and the placenta starts to form. The blastocyst receives nourishment and eliminates waste through the placenta. The amniotic sac begins to form. At this stage the foetus is called the embryo.

Cell division and differentiation is now rapid. Three layers are formed from which are produced respectively:

- the cuticle, brain, spinal cord and nerves
- the bones, muscles, blood vessels and connecting tissues
- the lining of the digestive system and glands

Specialised cell production has now begun.

Weeks 3–4 day 25 About 3 millimetres long. The embryo has now increased about 10 000 times in size from conception. The body and head have little shape. The heart and blood cells have formed; the heart begins to pulsate and embryonic blood vessels appear. The central nervous system has begun to develop.

Weeks 4–5 day 30 About 5–6 millimetres long; weight 1.3 grams. The shape is curved and not clearly differentiated between head and body, though head and tail folds appear. The primordia (or buds) of the limbs will now start to develop. The heart beat is regular. The primary brain, eyes, ears, mouth, kidneys, liver and umbilical cord are present.

Weeks 6–7 day 45 Nineteen millimetres long; weight about 2 grams. The head and eyes are distinguishable, also the beginnings of the limbs. The ears are formed. The skeleton is complete (in cartilage). There are short arms with rudimentary hands, fingers and thumbs; the legs have the beginnings of knees, ankles and toes. The buds of the milk teeth have formed. The nerves and muscles work together and the first movement may have occurred; the lips are sensitive to touch; all internal organs are present and the liver and kidneys can function.

35. Materials used in compilation of the timetable include: Submissions 131, RTLA (SA Div.) Inc.; 162, National RTLA vol. 2—The subject of abortion—the infant in utero; 994, Human Life Research Foundation of Vic.; Evidence, pp. 1223–46, Dr E. G. Cleary; Exhibits 19, *The everyday miracle* (Allen Lane, London, 1967), 78, 79, 194, *Abortion report*, Anglican Diocese of Sydney.

Week 8 day 56 Twenty-five millimetres long; weight about 3.5 grams. The face and jaws develop and the limbs have recognisable shape. The skeletal muscles have formed; movements are possible, the legs may kick and the eyelids are sensitive to touch. All elements of the adult EEG are present. The lungs and diaphragm are formed and the intestine has elongated. At this stage most differentiation of tissue has occurred and the embryo is a foetus. Everything is present. Thereafter differing rates of growth of different tissues give changing body proportions.

Weeks 8–16 Up to 150 millimetres long; weight about 220 grams. The foetus grows continuously. At 9 weeks it can make a fist and grasp. The sex glands have formed. At 12 weeks it has a facial expression and can inhale fluid into its lungs. At 16 weeks the arms and hands are fully shaped; the foetus moves in its fluid and the mother may feel it ‘quickening’. It responds to pain, touch and cold, drinks amniotic fluid, gets hiccups, wakes and sleeps.

Week 20 One hundred and fifty to 250 millimetres long; weight 400–500 grams.

Weeks 20–28 The foetus is entering the period of possible extra-uterine survival. Determining factors are maturity of central nervous system and respiratory system. Renal, alimentary and endocrine systems are usually reasonably capable of survival by the 26th week.

Week 32 month 8 The foetus can respond to noise and is putting on fat, improving temperature control etc.

9 months: birth About 508 millimetres long; weight about 3171 grams (3 kg).

Summary

71. This outline table shows that the process of development is continuous from conception to birth. There are certain stages, each emerging from the one before. There are only three clearly differentiated points—that of conception, that of implantation and that of birth. From the moment of fertilisation, or fusion of the male and female gametes within the fallopian tube, a new life has its beginning. Interference with this process, either by the prevention of implantation, or by the deliberate removal or destruction of the embryo or foetus, brings that new life to an end. This is what makes abortion an issue of serious concern to everyone.

The right to be born

72. Opponents of liberal abortion laws argue that human life must be respected and protected from the moment of conception. In this they attach significance to a passage in the preamble to the United Nations Declaration of the Rights of the Child (20 November 1959) as follows:

Whereas the child, by reason of his physical and mental immaturity, needs special safeguards and care including appropriate legal protection, before as well as after birth.³⁶

Principle 4 of the Declaration asserts that a child shall be entitled to grow and develop in health:

To this end special care and protection shall be provided both to him and to his mother, including adequate pre-natal and post-natal care.

73. The Declaration has been quoted in support of the proposition that an unborn child has a fundamental right to life. The right of the innocent to life is seen as an absolute right of man on which all other rights depend.³⁷

36. UN Declaration of the Rights of the Child (1959) preamble; this passage appeared in the original motion for an inquiry leading to the setting up of this Commission, see *Interim report*, Annex G, p. 35.

37. Submission 585, NSW RTLA.

74. Our attention was also drawn to the Declaration of Geneva, adopted by the World Medical Association in September 1948:

I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.³⁸

75. The International Code of Medical Ethics 1949 and the Declaration of Oslo adopted in 1970 by the World Medical Association contained similar statements. It was also submitted that since an infant at birth may claim certain rights (e.g. compensation for injury in pregnancy) there should be legal machinery to protect its survival during pregnancy.³⁹

76. The supporters of liberal abortion argue that the right to life includes the right to the basic needs of food, clothing, shelter and above all care and concern. This argument suggests that the child has the right to be wanted and that the unwanted child has a right not to be born. In this view the rights of the foetus and the rights of the mother are not in opposition to each other.⁴⁰

77. The approach of the Committee of the Presbyterian Church was as follows:

It is a serious decision to make that the life available for the child is so poor or that he or she is such a threat to another person that destruction is justifiable, but the Committee accepts that this can be so.⁴¹

78. In our view the abortion issue cannot be resolved by reference to a category of legal rights such as the right to be born. The assertion of any right has to be considered in the light of other competing or conflicting rights. In our present legal system legal rights attach to legal persons and an unborn child has no legal personality unless and until born alive. A child born alive may enforce claims of a retrospective kind. A stillborn child may not. The question whether abortion should be permissible and, if so, in what circumstances is of a different kind to the question whether rights of a particular kind should attach to a living person. Abortion involves consideration of moral and social values as well as legal norms. To talk in terms of a right to be born does not advance the issue other than to emphasise that a potential living person is destroyed in the termination of a pregnancy.

The moral issues

79. Religious and moral beliefs should be understood and respected, so far as they affect the freedom of action of those who hold them. Views on the abortion issue are not unanimous among Christian or Jewish religious groups.

80. The Catholic Church has always opposed abortion in modern times. The Papal encyclical *Humanae vitae*, issued on 25 July 1968, sets out the official teaching of the Church on contraception and declares that:

The direct interruption of the generative process already begun, and above all, directly willed and procured abortion, even if for therapeutic reasons, are to be absolutely excluded as licit means of regulating birth.⁴²

81. The Lutheran Church holds a similar view—that the foetus is human life created by God and entitled to care and preservation, the right to life and protection; abortion is not justified except possibly to save the mother, but she should first seek pastoral guidance.⁴³

38. Submission 994, Human Life Research Foundation, Vic.

39. Submission 176, Dr Jean Benjamin, Christian Medical Fellowship of Australia (NSW branch).

40. Evidence, p. 394, Bridget Gilling.

41. Report on abortion (Presbyterian Church, NSW, 1974), p. 13.

42. An earlier encyclical was issued on 29 October 1951, followed by a statement on 28 November 1951.

43. Submission 158, Lutheran Church of Australia, Commission on Social Questions.

82. The Anglican Church, Diocese of Sydney, believes that abortion can be justified only to save a mother's life or to prevent serious mental or physical illness, in the case of extremely young adolescents, or those whose pregnancies result from rape or incest.⁴⁴

83. An ad hoc committee of the Presbyterian Church of New South Wales considered:

That the law should not compel medical and paramedical personnel either to perform or not to perform abortions and that the circumstances under which these are done should be determined not by Parliament and the whole community but by individual hospitals, the medical profession and the patient.⁴⁵

They proposed that abortions performed by legally qualified personnel in proper hospitals should be removed from the realm of the criminal law. Their proposed amendment of the Crimes Act was adopted by the General Assembly.

84. The Congregational Union of Australia, at its 1973 Assembly, stated that abortion is 'not a black and white' issue for them, though some imply that there is only one Christian attitude. The Union would uphold 'planned parenthood' and deplore abortion as an alternative to sexual discipline or responsible contraceptive practice. They consider, however, that the final decision is for the woman and each woman is entitled to know her options.

Whilst recognising the sincerity of conviction of [other groups] . . . there are other Christians of equal sincerity . . . who believe that there should be uniform legislation throughout the Commonwealth which would make abortion more readily available as a legal procedure than is now the case.⁴⁶

85. Medical views are not unanimous. The Australian Council of the Royal College of Obstetricians and Gynaecologists consider that termination should be performed only when the continuation of the pregnancy would cause more pain (physical or mental) to the mother than its termination, or when the foetus is expected to be abnormal. The judgment should be a matter for discussion between patient and doctor, and the abortion should be done as early as possible in good conditions.⁴⁷

86. The Royal Australian College of General Practitioners consider that the confidentiality of the decision about termination should remain the province of doctor and patient alone.⁴⁸ The view of the Australian and New Zealand College of Psychiatrists is as follows:

. . . that the problem of unwanted pregnancies should be a matter between the doctor and his patient. That it should be part of his expertise, as a reflection of training and education, to recognise social, economic and psychological pressures acting on his patient, and to take into account the woman's state of general emotional health, maturity and general fitness for motherhood at the time in question.⁴⁹

87. Dr Peter Hoopman told the Commission how he had changed his view from opposing abortion:

It is extremely abhorrent; it is a terrible thing, but all the same I think that it is justifiable.⁵⁰

44. Submission 611, Anglican Diocese of Sydney. See also Submissions 138, Church of England, Diocese of Adelaide, Social Questions Committee; 818, Church of England, Diocese of Melbourne, Social Questions Committee.

45. Report on abortion (Presbyterian Church, NSW, 1974), p. 2.

46. Submission 995, Congregational Union of Australia (material put before the Commission includes a collection of views of some US religious groups who favour liberal abortion).

47. Submission 112, RCOG, Australian Council.

48. Submission 886, RACGP.

49. Submission 785, ANZ College of Psychiatrists.

50. Evidence, p. 1323, Dr P. Hoopman.

88. We do not accept that the beliefs of one group, even of a substantial group, should alone be the basis for controlling or punishing acts which do not affect them directly. When there are widely conflicting views about the moral and legal issues involved, a surer basis is required for the sanctions of the criminal law, a basis which should have the support of the majority.⁵¹

89. Many religious beliefs equate with common standards of morality accepted by all citizens and these in turn are reflected in the criminal law. But not all aspects of religion or morality are enforced by the criminal law. Morality and religion often condemn acts or call for positive action in circumstances where the act or failure to act do not offend against the law.

90. In commenting on the place of morality within the law, Justice Roma Mitchell said:

If the community as a whole does not regard as undesirable an act which the law prohibits as a crime, that particular crime will be likely to go unpunished.⁵²

The criminal law reflects society's common interests in protecting the person and property of its members. Does society have such an interest in preserving the life of the foetus that it should prohibit and punish abortion? Does the punishment of abortion cause greater harm than the act of abortion and does it in fact prevent abortion?

91. There is no majority view favouring absolute prohibition of abortion. Our section on attitudes to abortion in this chapter concludes that while there remains a polarisation of extreme views, there is also a high level of consensus: a majority of all major groups—even of Catholics—approve of the further legalisation of abortion. This suggests that many people do not see the life of the foetus in absolute terms.

92. There is some justification for regarding foetal life as different in quality to the life of a human being after birth, particularly in the response which it evokes from other human beings. The foetus is certainly human life, and it contains within it all the elements for development and growth as a human being. Nevertheless, at least in the early stages of pregnancy, it cannot be seen or heard or touched or felt or recognised as an identifiable person, and it is inherently incapable of being involved in a human relationship other than in the mental imagery of the mother and father. None of these statements is true of a human being once born alive.

93. This distinction does not necessarily resolve the moral or religious debate over abortion since some involved in that debate do not admit any qualification on the absolute value of human life. Nevertheless it seems to us to have important consequences affecting the social and legal issues. The first is that people are prepared to take into account the social circumstances of the mother and her family in their view of abortion. In other words, even though they may see abortion as undesirable (or even as immoral) they are prepared to accept it or at least not to condemn it where they see a genuine need; alternatively they see the life of the foetus as being solely the concern of the mother.

94. The second important consequence is relevant to the argument often raised by those opposing abortion, namely that its acceptance opens the way to acceptance of euthanasia of the aged and the grossly handicapped:

51. Williams writes: 'if moral rules are to be externalised and enforced by law, they should so far as possible be those that human beings in the mass are able to comply with, without excessive repression and frustration and without over-much need for the actual working of the legal machine' (p. 211); see also Lord Devlin, *The reinforcement of morals* (Oxford University Press, London, 1959); H. L. A. Hart, *Law, liberty and morality* (Oxford University Press, London, 1963).

52. Justice Roma Mitchell, *The web of criminal law* (SA Govt Printer, Adelaide, 1975) p. 12.

Assigning humanity only to selected classes promotes grave dangers in the ultimate solution of problems of handicap, congenital or acquired, and of failing health . . . [It leads] to arbitrary judgments about 'the life not worth living' and 'the unwanted'.⁵³

They see infanticide and euthanasia as the natural successors of liberal abortion. In their view to accept abortion would be to create a dehumanised society built on self-centred personal pursuits; it would degrade the medical profession and be contrary to the Declaration of Geneva.⁵⁴ They point out that those supporting liberal abortion laws also support euthanasia. The connection with euthanasia is denied by some proponents of reform.⁵⁵ One submission mentioned that those opposing abortion also support capital punishment.⁵⁶

95. In our view the nature of foetal life makes the abortion issue distinguishable from euthanasia. Compassion for living human beings is not inconsistent with acceptance of abortion. A humane and compassionate society would consider the problems and needs of the pregnant woman and this is compatible with the statement of Albert Schweitzer which was quoted to us:

If a man loses reverence for any part of life he will lose his reverence for all life.⁵⁷

96. It does not follow that abortion is seen as a desirable end in itself; foetal life is human life and its destruction must cause concern. The following comment of Mr Leo Abse, MP, was quoted to us by the British Society for the Protection of the Unborn Child:

Any abortion law, wide or narrow, is a failure of society. Every abortion is a failure either because medicine has not advanced enough to protect mother and child or because our social welfare system does not give proper support.⁵⁸

97. It is rather that, however repugnant abortion may be to the conscience, resort to moral standards cannot resolve the complex issues involved; there is no absolute moral standard and there may be no authority to resolve the moral debate if, indeed, it is capable of resolution. The consequences of abortion must be weighed in the balance against the consequences of proceeding with an unwanted pregnancy. This leaves the questions—how is such an assessment to be made, and what is the role of the law?

The role of the law

98. If, as we believe, there is no absolute moral standard to resolve the abortion issue, the question arises how to determine those circumstances in which abortion is justifiable and whether the criminal law should play any part in that determination. Among those who favour legal regulation of abortion, it is often argued that unless access to abortion is restricted there will be a tendency to use abortion as a means of contraception. It is also argued that there is a legitimate public interest in restricting abortion to defined circumstances.

Abortion and contraception

99. There is an agreed need to reduce the number of abortions by encouraging better contraceptive facilities and practices. There is a strong fear in some that if abortion

53. Submission 162, NRTLA.

54. Submission 994, Human Life Research Foundation of Victoria.

55. e.g. Submission 58, Womens Abortion Action Campaign.

56. Submission 514, Mr T. W. Goulden, comprising an article by James W. Prescott in *The Humanist* referring to studies by B. C. Ayres on the question whether societies that permit and practise abortion are characterised by disrespect for human life.

57. Submission 585, NSW RTLA.

58. Submission 1047, UK Society for Protection of the Unborn Child.

were more readily available it would be seen as an alternative to proper contraceptive practices. Some of our submissions put the view that liberal abortion laws would lead to disregard of family planning services.⁵⁹

... a disturbing number of abortions are carried out where liberal laws exist; in fact there is evidence from all over the world that where liberal laws regarding abortion exist, there is disregard of family planning services.⁶⁰

100. This fear led to the suggestion that the Commonwealth government should withdraw funds from family planning programs in any State which does not prohibit abortion other than to save the mother's life.⁶¹ On the face of it this would appear to be a most irresponsible move. It is difficult to establish from existing figures that there is likely to be any significant departure from contraceptive practice because of the availability of abortion. Some of our submissions refuted the suggestion that women would use abortion as a means of fertility control.⁶² There is evidence that it is the custom of some southern European immigrants to resort to abortion when their preferred method of contraception, withdrawal, fails. There is no evidence of a decline in use of contraceptive services; on the contrary there is a steady increase in resort to clinics.

101. Figures published in England show a steady off and a gradual decline in the number of abortions performed on resident women as follows:

| | |
|------|-----------------------------------|
| 1974 | 109 432 |
| 1975 | 106 648 |
| 1976 | 102 000 (Jan.-Nov. estimate Dec.) |

A further decline may follow as family planning services are extended. (The provision of free contraception under the National Health Service began in 1975.)

102. It is debatable whether there are men and women who would have unprotected intercourse with the thought in mind that an unwanted pregnancy could be terminated. It seems more probable that, human nature being what it is, there is often ignorance, little thought of the consequences, or at best the hope that pregnancy will not occur. There is also the possibility that some women may not have the option to refuse unprotected intercourse.

103. We do not consider that easier access to abortion would be seen as a substitute for effective contraception. We argue strongly for the expansion of contraceptive services and of educational programs aimed at raising motivation towards effective contraception. However, we do not consider that these steps will eliminate entirely the need for abortion, though in the long term they would have some effect.

Defining the circumstances: who decides?

104. Because we and so many people accept that abortion is justifiable in certain circumstances, we must now consider whether it is possible to define those circumstances and whether the area is susceptible to effective legal regulation.

105. For reasons already mentioned, laws which prohibit or limit abortion do not prevent abortions, or the demand for abortion, and are themselves attended by a number of undesirable consequences. These include the number of illegal abortions with high morbidity rates and high death rates; criminalisation and corruption of the abortion trade; financial exploitation of women; psychological consequences; lack of proper procedures and counselling.

59. Submissions 522, RTLA (Tas.); 1146, Dr J. J. Billings; 131, RTLA SA.

60. Submission 1146, Dr J. J. Billings.

61. Submission 131, SA RTLA.

62. Submission 197, RTLA, ACT; Evidence pp. 798 ff, Prof. J. Leeton.

106. Decisions about abortion require a balancing of factors; a weighing up of the risks to physical and mental health and the social consequences in proceeding or not proceeding with the pregnancy. How should this difficult task of assessment be performed? Is it a matter to be decided by a doctor (or by two doctors), or is it a matter for the woman herself? At present the legality of the decision depends on the circumstances of the woman herself, on the opinion formed about those circumstances by one or two doctors and on the view taken of the matter by a court at a later date.

107. This seems a highly inappropriate proceeding; the woman is dependent on the subjective view of the doctor and he in turn is liable to have his view tested by others who may make a different subjective assessment. It would be impossible and undesirable to lay down strictly objective criteria. The fact that legal proceedings are rare in this country suggests that these issues are not susceptible to legal determination.

108. The uncertainty of the law can mean that a woman is denied abortion, or it is delayed, with increased risks.

109. The persons best placed to assess the need for an abortion are the woman herself and her doctor. The doctor's task is to weigh up the circumstances, advise on the risks and to ensure proper medical practice.⁶³ To help the woman in her decision she may benefit from skilled counselling; this is a role which the medical profession is not always able to fill and which may require other trained personnel. It is a role which is equal in importance to the medical role.⁶⁴ While others can help her to envisage the possible outcomes, no one is as well placed as she is to decide the effects of proceeding or of not proceeding with the pregnancy. The life and health of the foetus are totally dependent on her and her decision is not taken lightly. The reasons given by women for seeking abortions are not irresponsible but suggest a genuine concern for the future.

110. When Simone Veil introduced the law permitting abortion in France she posed the question whether abortion could be permitted without society appearing to encourage it. Her answer was to point out that no woman has recourse to abortion with a light heart: 'It is always a drama and will always remain a drama'.⁶⁵ This view is echoed by one of our own contributors, a mother of six, who had an abortion at the age of 22 when she could see no way out and who continued to feel remorse for many years:

I would do all I could to help a girl *not* to have an abortion but if she chose to have it I would do all I could to help her to find the right place—don't speak out against abortion until you have experienced it yourself.⁶⁶

111. Once a woman has considered the outcomes and reached a decision, we do not think that any public interest is served by laying down conditions binding upon the medical profession and backed up by the sanction of criminal law. To do so is to imply that the parties most concerned will not act in good faith. We can see no benefits in a law which makes it a criminal offence for a doctor to perform an abortion at the request of a pregnant woman. There is a need for proper counselling but this does not require legal regulation. The only matter which, in our view, does require legal regulation is the setting of a time limit for the performance of abortions with reference to the viability of the foetus.

63. Submission 785, ANZ College of Psychiatrists.

64. *ibid.*, quoting article by Gold.

65. Journal Officiel, Débats, Assemblée Nationale, 26 November 1974, p. 6999: 'C'est toujours un drame et cela restera toujours un drame.'

66. Submission 567, name withheld.

Abortion on demand: the medical role

112. This does not mean that we support 'abortion on demand'. The Lane report distinguished between abortion on demand and abortion on request as follows:

By abortion on demand we mean a situation where the woman asserts a right to abortion regardless of the doctor's professional opinion; on the other hand abortion on request would involve a right thereto without regard to any statutory criteria but subject to a doctor's professional approval and willingness to perform the operation.⁶⁷

113. The Lane Committee recommended against abortion solely on the request of the woman in the following terms:

The modern concept of medical care is, or is becoming, that a patient should be treated as a whole person viewed in the light of personal physical and mental health and social conditions and not merely as one suffering from a particular disease or condition requiring amelioration or cure. Given this wider view, in our opinion it is in the interests of the patient as an individual that the abortion decision should be taken by doctors; that the latter should continue to exercise their clinical judgment after making an assessment of the woman's health and situation rather than be restricted to ensuring that she was medically fit to undergo abortion . . .

To expect doctors to operate under orders without reference to their judgment would be contrary to good medical practice and would also be to the disadvantage of their patients especially having regard to the complexities and uncertainties of the outcome of the operation . . .

Further, some women would find the burden of making their own decision unsupported a heavy one and in such cases the operation might well be followed by emotional turmoil and feelings of guilt. Additionally, they would be more vulnerable to pressure from parents, husbands or boyfriends. Another disadvantage of permitting abortion on demand might in some cases be to encourage neglect of contraceptive precautions. Furthermore, the already high number of abortions would almost certainly be inflated and we consider it probable that many obstetricians and gynaecologists would be unwilling to operate under such a system.⁶⁸

114. The Committee also stated that the NHS could not undertake abortions on the grounds only of a patient's wishes or convenience and that a legal right to abortion on demand or request might be unenforceable.⁶⁹ The report notes that public opinion was still against abortion on demand or on request.

115. We agree with the reasoning of the extract just quoted and we accept that doctors should 'continue to exercise their clinical judgment after making an assessment of the woman's health and situation rather than be restricted to ensuring that she was medically fit to undergo abortion'. We do not, however, consider that the rigour of the criminal law is needed to ensure this.

116. Nor do we consider that a doctor should be obliged to provide abortion services to any woman on request if he is opposed to abortion or if he does not consider it appropriate for a particular patient.⁷⁰ If a doctor is willing to provide abortion services for a woman requesting such service and is satisfied as to her need and her condition, the law should not intervene to test whether the doctor was entitled to form a view in favour of the abortion. The doctor's clinical judgment should be unfettered by legal sanctions either in favour of or against abortion. The establishment of specialised clinics or hospital units to deal with abortion could help to overcome problems arising from a particular doctor's objection to taking part in the procedure.

67. Lane report, vol. I, p. 64, para. 188.

68. *ibid.*, para. 190.

69. *ibid.*, para. 191.

70. For a discussion of these issues see M. Simms, 'Abortion law and medical freedom', *Brit. Journal of Criminology* (1974), p. 118.

117. Our comments about doctors apply equally to nurses and to other paramedical staff. None should be obliged or required to take part in an abortion if unwilling to do so.

Counselling

118. The Lane Committee concluded that some women would find the burden of making their own decision unsupported a heavy one, and might be vulnerable to pressure from parents, husbands or boyfriends. Some of our submissions stressed the need for skilled counselling for a woman seeking abortion.⁷¹ It is important for her to discuss the situation fully with an impartial person to avoid the influence of family and other pressure. The woman often needs help in considering the options which are available to her in her situation and in exploring her own feelings. She may need advice on contraception and, if the abortion proceeds, an opportunity for further counselling.

119. It is important that proper counselling services be established and supported to provide helpful, non-directive counselling for women seeking an abortion, should they require it. We do not consider that counselling should be a compulsory legal requirement; it is more important to ensure that the facilities are provided. Some suggest that such services should be independent of abortion services. While it would be ideal to provide independent counselling services, it would not be practicable or desirable that these should replace existing counselling services at abortion clinics. Many women might not get any counselling at all unless the services were attached to the clinic. The important thing is to ensure high standards and adequate facilities.⁷²

Family consultation

120. Our terms of reference require us to consider 'the consultative rights of the family or other persons concerned'. We received a few submissions suggesting consultative rights⁷³ and others opposing the idea.⁷⁴ We have considered the question and we have formed the view that this is an area where moral and social values cannot necessarily be reflected by legal rules. There are many cases where we think it would be proper and, indeed, desirable for a woman to consult her husband or partner, or for a young girl to discuss the matter with her parents before deciding to ask for an abortion. There are many who do this and will continue to do so. In some cases the counsellor may suggest this course of action. It may help the woman, though there is sometimes a danger of undue pressure either to have or not to have an abortion. The counsellor is needed to help the woman in an impartial assessment of the situation. The position of minors requires special consideration.

121. In the case of adults we can see no justification for imposing a legal condition that any person must be consulted; nor a condition requiring the consent of any person other than the woman concerned as a prerequisite to abortion. However distressing the matter may be to the partner of the woman concerned, he should not be able to obstruct her decision.

122. We note that the US Supreme Court, on 1 July 1976, declared unconstitutional state laws requiring the consent of the husband (or the parents of a minor) to an abortion in the first trimester.⁷⁵ Justice Blackman observed:

The obvious fact is that when a husband and wife disagree on this decision, the view of only one of the two marriage partners can prevail. Since it is the woman who physically

71. Submissions 273, Mrs F. D'Souza; 570, Preterm Foundation; 611, Anglican Diocese of Sydney.

72. In Sweden counselling services are to be provided for every woman seeking abortion, on a voluntary basis, i.e. it is not compulsory ('Swedish legislation on abortion', *Fact sheets on Sweden*, February 1975).

73. Submissions 273, Mrs F. D'Souza; 824, Mr Geoff Johnston.

74. Submissions 58, WAAC; 335, Abortion Counselling Service, Canberra; 886, RACGP.

75. See para. 136 of this chapter.

bears the child and who is the more directly and immediately affected by the pregnancy, as between the two, the balance weighs in her favour.⁷⁶

Panels: assessors

123. One submission proposed that any woman having an abortion should be required to obtain a certificate from an independent medical assessor (paid by the government and excluded from receiving any form of payment from the woman).⁷⁷ The advantages of such a system are said to be that it would ensure notification and follow-up, would help a woman who was being pressured, would enable control of the private sector, reduce pressure on doctors and hospitals and enable consultation with other family members. It was thought that delays should not be more than 2 weeks, even with an appeal system.

124. Another submission suggested regional committees of seven members to decide on requests for abortion. If no decision were reached after 1 month the abortion could proceed.⁷⁸

125. The panel system in operation in the ACT was described to us:

The procedure is as follows: the woman's request for an abortion must be approved by two doctors who feel that her application is justified according to their consciences and expertise in the relevant medical specialty, e.g. obstetrics, psychiatry; the case is then documented and presented to an impartial panel of doctors which includes the Medical Superintendent of the Canberra Community Hospital; if the panel agrees that the grounds for abortion are 'reasonable', the hospital management sanctions the use of its facilities for the procedure.⁷⁹

126. Others opposed any system of panels or assessors on the grounds that they added to the number who may take differing views of a situation and lead to delays. It is pointed out that they are not needed to ensure notification or counselling and that public scrutiny of medical practice is the best way to overcome abuse. It was mentioned that only four out of 284 cases going to the committee had in fact been refused.

127. The Canadian Royal Commission on the Status of Women found that 'Requiring the approval of a hospital therapeutic abortion committee has the effect of limiting the possibility of obtaining legal abortion' due to difficulties in getting approval and delay.⁸⁰ The Lane Committee concluded that a panel or referee system would lead to delay, would not bring uniformity and would interfere with the doctor-patient relationship.⁸¹

128. It follows from what we have said about decisions on abortion that we do not accept the proposal that decisions about abortion should be referred to a panel or to referees. Nor do we consider it necessary for a second medical opinion to be obtained.⁸²

129. While reference to a second opinion is a useful safeguard for the medical profession, when the legality of the abortion depends on the doctor's assessment of the case, it is not necessary to ensure proper medical practice or for any other purpose under the procedure we propose.⁸³

76. *New York Times*, 2 July 1976; *Family Planning Perspectives* 4 (1976), p. 177.

77. Submission 197, ACT RTLA; see also Submissions 818, Church of England, Diocese of Melbourne, Social Questions Committee; 1047, the UK Society for the Protection of the Unborn Child.

78. Submission 1172, Rev. Robert Ower.

79. Submission 197, ACT RTLA.

80. *Report on status of women in Canada*, p. 284, para. 233.

81. Lane report, vol. I, paras 194-6.

82. See Submission 785, ANZ College of Psychiatrists.

83. See comments of Prof. Cox, Evidence, p. 1410.

Conclusions

130. Our conclusions about the role of law in abortion are that:

- (a) subject to what is said later about time limits, abortion should be free of legal regulation when performed by a registered medical practitioner at the request of the woman;
- (b) no doctor, nurse or other person should be required to take part in an abortion if he or she is unwilling to do so;
- (c) counselling services should be provided to every woman seeking abortion to ensure that she makes a free choice: these should be supported by public funds;
- (d) the consent of a woman's husband or partner should not be required as a condition of an abortion.

131. Some submissions suggested that there would be advantages in trying to establish uniform abortion laws in Australia. We agree that it would be desirable to avoid interstate traffic and the unequal access to services which now occurs. However, we appreciate that in an area of sharply divided opinion and strongly held views there are many obstacles to changing the law.

132. We believe that the abortion law has been allowed to lapse in some States and Territories since no attempt is made to enforce it or to test its limits. Because it exists abuses still occur and there is a lack of public scrutiny of abortion practice. In other States uncertainty about the law or restrictive laws mean that abortion is not available openly.

133. In our view if a law is not enforced or is inherently unenforceable it should be repealed. Abortion laws fit both these criteria. Pending the repeal of the laws we consider that a declaration should be made that no criminal proceedings will be taken against a medical practitioner who performs an abortion in appropriate conditions within the time limits we propose and at the request of the woman.

134. Such a declaration would help to overcome abuse, to ensure proper public and medical scrutiny of existing services.

Time limits on abortion: viability

The stages of pregnancy

135. The question whether there should be any upper time limit on abortion depends to some extent on the viability of the foetus, on the risks of abortion and on the stages of pregnancy.

136. In medical terms the medical practice and the risks of abortion vary at each of the three stages, called trimesters, which broadly correspond with the three periods of 3 months of the pregnancy. The duration of the pregnancy is usually taken from the start of the last menstrual period. This is not the same as the duration of 'foetal life' or the gestation period, which is taken from the date of fertilisation, some 2 weeks later. This distinction is important to the following discussion.

First trimester (pregnancy up to 12 weeks; foetal life up to 10 weeks)

137. This is the period when an abortion can be performed with the least risk. Abortion and counselling services should be planned and provided in such a way as to avoid delay and to make it possible for women who seek an abortion to have it in the first trimester. There is no case for legal regulation of abortion in the first trimester.

Second trimester (pregnancy 12–24 weeks; foetal life 10–22 weeks)

138. Abortion during the second trimester carries more risk for the woman and involves more complex surgical procedures. The foetus develops into an increasingly recognisable human form and is approaching the point of viability. Because of these factors medical and nursing staff often find it distressing to be involved in abortion at this stage. Sometimes the existence of a defect in the foetus cannot be determined till the 16th week or after, and in other cases abortions have to be performed in this period for medical reasons.

Third trimester (pregnancy 24 weeks onwards; foetal life 22 weeks onwards) The foetus develops to the point of ‘viability’.

139. It would be preferable if all abortions could be performed in the first trimester; some have suggested that the law should allow abortion free of sanctions in the first trimester, and that during the second trimester abortion should be permissible only in certain defined circumstances. There are arguments against such a solution: it is sometimes difficult to know precisely what stage the pregnancy has reached; this would lead to uncertainty in the operation of the law. Although the risk to the mother is greater, this is a matter for medical judgment and advice; the woman needs to have proper information and counselling.

140. It could be argued that the need for legal restriction increases as the foetus approaches viability. This argument would find no support from those who believe in the humanity of the foetus from conception or implantation, but there are many who do feel that the balance shifts against abortion as the foetus develops.

Viability

Definition

141. We define viability as follows:

In the context of pregnancy and abortion—the quality of having life or capability of living ex utero, outside the mother’s body.

The following definition is from the Lane report:

Viable: a term applied to a foetus which is capable of leading a separate existence.⁸⁴

The Peel report on the use of foetuses and foetal material for research defines a viable foetus as:

... one which has reached the stage of maintaining the co-ordinated operation of its component parts so that it is capable of functioning as a self-sustaining whole independently of any connection with the mother.

and a pre-viable foetus as:

... one which, although it may show some but not all signs of life, has not yet reached the stage at which it is able, and is incapable of being made able, to function as a self-sustaining whole independently of any connection with the mother.⁸⁵

142. The Supreme Court of the United States recently upheld a state law defining viability as:

... that stage of foetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems.⁸⁶

84. Lane report, vol. I, p. 271.

85. See Submission 1105, ACT RTLA.

86. *Family Planning Perspectives* 4 (1976), p. 178.

143. It is impossible to fix a time for viability which has universal application. There is some uncertainty in each individual case about the date of commencement of the pregnancy; and each foetus may have its own pace of development. Nevertheless, definitions of viability have been developed for the following purposes:

- to fix an upper limit on the time within which abortion may be performed
- to fix a time after which the delivery of the foetus has to be recorded
- to fix a time at which infant destruction laws come into operation

144. Dr Hilgers told the Commission about the many differing definitions of viability and stressed that ultimately the ability of a child to live outside his mother's womb at a very early age depends upon the child himself:

The youngest reported survivor weighed 397 grams on the second day of life, and a recent report from Poland described the survival of an infant who weighed 450 grams at birth with a weight reduction to 360 grams some days later who was alive and doing well at 3 months of age.⁸⁷

145. A submission to us from the Right to Life Association stated that in the US viability had been progressively reduced from 28 to 24 and then to 20 weeks gestation age, and informed the Commission that some infants have survived as young as 21–23 weeks. They predicted that in future viability would be reduced to 12 weeks.⁸⁸

England

146. The Lane Committee considered the question of viability and the upper limit for abortion. In their view a limit of 28 weeks would be too high in view of modern methods of sustaining premature infants:

Viability must be a question of fact in each case but, while it may be theoretically possible for a foetus to survive at 24 weeks gestation, in practice there is little hope of survival at a gestational age of less than 26 weeks . . . we know of no case in this country in which anyone has been able to say that a foetus of less than 24 weeks gestation was viable in the sense that it could have survived even the peri-natal period.⁸⁹

Although they were aware that some abnormalities could not be detected until 24 weeks, they did not think the time limit should be extended on the ground of abnormality.

147. The Committee recommended that the upper time limit of 28 weeks for abortion be reduced to 24 weeks (from the date of the last menstrual period—22 weeks foetal life)⁹⁰. Where termination of pregnancy is medically necessary after that time, the Committee recommended that it be treated as induction of labour, that every effort should be made to preserve the life of the child and that all statutory requirements as to obstetric care, notification and registration of the birth as a live birth or stillbirth must be observed.

148. The Peel report had recommended that the minimal limit of viability for human foetuses should be regarded as 20 weeks gestational age, which corresponds to a weight of approximately 400–500 grams.⁹¹

149. The House of Commons Select Committee on Abortion recommended in July 1976 that an upper time limit of 20 weeks be fixed for termination, except where the child may be born with a major disability or where the mother's life or health is at stake.

87. Evidence, p. 200, Dr T. W. Hilgers; Exhibit 13, p. 35.

88. Submission 131, RTLA, SA.

89. Lane report, vol. I, p. 90, para. 279.

90. *ibid.*, paras 280–3.

91. Peel report, para. 31.

United States

150. The US Supreme Court recently overturned a state law which required the physician to exercise as much care and skill to 'preserve the life and health' of an aborted foetus as of one intended to be born alive, without specifying that this requirement applied only to viable foetuses. The law provided that a physician not providing the required level of care would be guilty of manslaughter. The decision preserves the principle of *Roe v. Wade* that 'The determination of whether a particular foetus is viable is, and must be, a matter for the judgment of the responsible attending physician'.⁹²

World Health Organisation

151. The members of the WHO scientific group expressed a preference for 20 weeks (from conception) as the upper gestational limit in defining abortion:

It has traditionally been assumed that viability is attained at 28 weeks of gestation, corresponding to a foetal weight of approximately 1000 g. This definition is based on the observation that infants below this weight have little chance of survival, while the mortality of infants above 1000 g declines rapidly. In recent years, some authorities have placed the upper limit of abortion at 20 weeks or at 500 or even 400 g because some infants of this weight have in fact survived, and the term 'immature' has been used to describe foetuses weighing between 500 (or 400) and 1000 g. The ætiological and clinical factors associated with intermediate foetal deaths (20–27 weeks) are in fact more similar to those found later in pregnancy than to those found in the early group.⁹³

152. Despite this comment they retained the traditional limit of 28 weeks because it is used in most countries with a definition of abortion.

Sweden

153. Swedish law has fixed 18 weeks as the upper limit, after which abortion is permissible only by the Board of Health and Welfare if there are particularly strong reasons for such a measure. A social worker would investigate the case. The period was fixed having regard to international moves to fix a limit of 22 weeks (500 grams) and to the difficulties in fixing the date of conception.

Conclusion

154. If abortion is to take place it should be performed in the first trimester. In an ideal situation there would be no need to set limits on abortion, as it would always be done early except where a risk to the mother arose or diagnosis of foetal defect occurred later.

155. We have considered the material before us and in particular the evidence about the survival period. The period during which abortion should be free of regulation should be fixed having regard to the known scientific evidence about viability. No one can know in advance whether a particular foetus is able to survive at a given date; there should be a bias in favour of a foetus as it approaches viability. In our opinion the period of 20 weeks gestation age (22 weeks pregnancy) should be fixed as the outer limit for abortion without any legal restriction. We now consider the position after that date.

Late abortion and infant preservation

156. The period of viability fixed for legal abortion leaves open the question of what should happen beyond that period. There are three issues to consider: the possibility of defects or abnormalities in the foetus, the mother's life or health, and the question of the preservation of the infant's life.

92. *Family Planning Perspectives* 4 (1976), pp. 177–8.

93. *Spontaneous and induced abortions*, p. 6.

Abnormalities

157. In view of our earlier conclusions, it is not necessary to consider the possibility of physical or mental abnormalities of the infant as a general ground for abortion up to the twenty-second week. Under the law in South Australia and in the Northern Territory, the possibility of such serious handicap is a ground for abortion up to 28 weeks. When the House of Commons Select Committee recommended an upper limit for abortion of 20 weeks, they made an exception in the case where the child may be born with a major disability.

158. The Lane Committee acknowledged that in some cases abnormalities could not be detected until fairly late.

The diagnosis of chromosomal abnormalities in the foetus, although often possible by 18 or 19 weeks gestation, may in some cases not be made until the end of the twenty-second week. Further, in the detection of biochemical abnormalities diagnosis may not be made until 24 weeks gestation.⁹⁴

159. We appreciate that there are some who do not consider that the possibility of handicap should be a ground for abortion at all.⁹⁵ In their view predictions do not cover the individual's capacity for happiness; they consider that the pregnancy should go to full term and the decision should then be made whether treatment should be given or withheld. The choice should be between those likely to die and those who can be treated and adapt to their life.

160. We do not agree with this view. It would impose quite unnecessary hardship and suffering on parents, on the child and on other children of the family. The fixing of a time limit for abortion ought not to preclude abortions performed after that date in the case of physical or mental abnormalities likely to lead to serious handicap.

The mother's life or health

161. In some cases a serious risk to the mother's health may make it medically necessary to terminate a pregnancy after the twenty-second week. Where this occurs we would adopt the view of the Lane Committee.

In order to preserve the life or health of the mother, or the child, termination of a pregnancy may be medically necessary in some cases after the twenty-fourth week of gestation and up to, or beyond, the normal date for delivery of the child. In this event, termination should be treated as induction of labour; every effort should be made to preserve the life of the child and all the statutory requirements as to obstetric care, notification and registration of the birth as a live birth or as a stillbirth must be observed. We consider that this should afford appropriate protection for a viable foetus.⁹⁶

Infant preservation and child destruction

162. In some countries there are provisions making it an offence to destroy a child at the time of birth. In some cases the operation of the law depends on whether the child was born alive or was capable of being born alive. For example, the New Zealand Crimes Act 1961, section 182, provides as follows:

Killing an unborn child

- (1) Every one is liable to imprisonment for a term not exceeding 14 years who causes the death of any child that has not become a human being in such a manner that he would have been guilty of murder if the child *had* become a human being.
- (2) No one is guilty of any crime who before or during the birth of any child causes its death by means employed in good faith for the preservation of the life of the mother.⁹⁷

94. Lane report, vol. I, para. 279 (2).

95. Submission 446, Drs J. Quoye and B. Kearney.

96. Lane report, vol. I, para. 281.

97. The history of this provision was considered by Richmond J. in *R. v. Woolnough*, 1976 NZ C of A; it seems intended to remedy a gap between abortion and homicide.

163. Under the English Infant Life (Preservation) Act 1929, an offence is committed by:

Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act, causes a child to die before it has an existence independent of its mother . . .

Evidence that a woman had at any material time been pregnant for a period of 28 weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive. No offence is committed unless it is proved that the act was not done in good faith for the purpose only of preserving the life of the mother.

164. These provisions were intended to deal with child murder but, as the Lane Committee points out, they make it unlawful for termination of the pregnancy to be carried out by a method which destroys a foetus capable of being born alive unless this is done to preserve the life of the mother. The Committee recommended that abortion be authorised only up to the twenty-fourth week of pregnancy and that after that date every effort should be made to preserve the life of the child. They also recommended the repeal of the 28-week provision in the 1929 Act to make it clear that the offence can be committed at any time.

165. Provisions similar to the UK Act, with the 28-weeks provision, exist in Victoria⁹⁸ and South Australia.⁹⁹ In Queensland and Western Australia there are similar sections relating to the crime of child destruction. Section 294 of the Queensland Criminal Code reads:

When a child dies in consequence of an act done or omitted to be done by any person before or during its birth, the person who did or omitted to do such act is deemed to have killed the child.

Section 271 of the Western Australian Criminal Code is in all material respects the same. Neither of these sections qualifies the crime by reference to 'intent' nor do they place any limitation on how long 'before' the birth the action or omission can have taken place. The codes do define a child capable of being murdered, for the purposes of the Act, as:

When it has completely proceeded in a living state from the body of the mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel string is severed or not.¹⁰⁰

166. None of these sections have been interpreted with respect to the question of abortion or the issue of the viability of the foetus. Because none of the Australian legislatures have defined 'child' adequately for the purposes of crimes relating to abortion these questions could become legal issues in the future.

Australian Capital Territory

167. The Draft Criminal Code published in 1975 by the Working Party on Territorial Criminal Law contained a provision similar to the English Infant Life (Preservation) Act 1929.

Section 24

- (1) Any person who by any means recklessly destroys the life of a child capable of being born alive and before it has an existence independent of its mother is guilty of an offence.
- (2) Evidence that a woman had at any material time been pregnant for a period of 28 weeks or more shall be prima facie proof that she was at the time pregnant of a child capable of being born alive.

98. Section 10, Victorian Crimes Act.

99. Section 82 (a) (7), SA Criminal Law Consolidation Act.

100. Section 292, Qld Criminal Code; section 269, WA Criminal Code.

168. It was submitted to the Standing Committee on Public Finance and Legislation of the Australian Capital Territory Legislative Assembly, by the ACT Right to Life Association, that this section would enable:

. . . the defence to a charge of abortion to claim that the destruction of the life of a child under 28 weeks of pregnancy was not prohibited. That is to say, there would be no obligation for medical staff to attempt to save the life of a child if it were from a pregnancy of less than 28 weeks.

169. The lack of a law relating to child destruction was highlighted in a recent case in the ACT. A woman was charged with murdering her newly born baby. Blackburn J. ruled that a child was not a life in being (and thus capable of being murdered) until it was completely separated from its mother and had begun to take in air. As there was no evidence that the baby had breathed after birth, the judge directed an acquittal.¹⁰¹

170. There appears to be a gap in the law which forbids termination of pregnancy, but not the destruction at birth of a child capable of being born alive. We think, in principle, it should be an offence to destroy the life of a child capable of being born alive unless the act is done in good faith to preserve the mother's life. Such a provision should be aimed against destruction of a child at the time of birth and should not cut down the circumstances in which an abortion may be authorised. The question whether a particular foetus is capable of surviving is a question of fact which cannot be determined in advance.

171. Where abortion is authorised, the doctor should, in our view, be free to choose the most appropriate means of termination, and should not be liable to prosecution for child destruction. That offence should not apply to acts properly done in connection with an authorised abortion, but should be confined to acts intended to bring about, and which result in, the destruction of the child, being acts unrelated to the abortion.

172. Another apparent inconsistency in the law of the ACT drawn to our attention concerned the registration of births. The ACT Right to Life Association points out that the Births, Deaths and Marriage Ordinance (ACT) defines a child as being some 400 grams weight (or 20 weeks gestation). Section 85 of the *Crimes Ordinance* 1951 (ACT) provides, as a defence to the crime of concealment of birth, that if the body in respect of which the concealment took place had issued from the body of its mother before the expiration of the twenty-eighth week of pregnancy, no crime has been committed.

173. We have not been able to investigate this matter; on the face of it the two provisions serve different purposes. The implementation of our main recommendations would lead to some consequential amendments and this issue could be considered at that time.

Abortion services

Introduction

174. In this section we consider and evaluate the services now available for termination of pregnancy in Australia and make recommendations for the improvement of services. In doing so we draw upon some of the results of our research project on intake procedures of a sample of hospitals and private abortion clinics with regard to patients requesting termination of pregnancy.¹⁰² We also rely on the results of our research into the consequences of termination of pregnancy, at Annexe IV.P.

¹⁰¹. *Canberra Times*, 28 October 1976.

¹⁰². Commission research report, no. 3 (the project has not been fully written up but the data are available).

175. An abortion service is a medical service whose prime function is to provide termination of pregnancy operations for clients. These services are distinguished from contraceptive services by the fact that the clients of abortion services usually present with a request for an abortion. Abortion services also provide other services, such as contraception, counselling and referral, pathology and treatment of sexually transmitted diseases.

176. There are three kinds of abortion services in Australia. There are 'free-standing' abortion clinics which have been set up specifically to provide the service. There are abortion services provided by private medical practitioners, GPs or gynaecologists, some of whom are full-time abortion specialists in the sense that this is how they earn the greater part of their livelihood. There are also abortion services in hospitals.

177. Abortion services of one kind or another exist in all States in Australia today, although the distribution of each kind of service varies considerably. Important changes in the law since 1969 have had a significant effect on the availability of abortion. It is more easily obtained in some States and Territories than in others, due mainly to differences in the law. For example, the South Australian legislation is the most liberal on the face of it, but in practice there are fewer legal restrictions on abortion in NSW and Victoria, where the only free-standing clinics have been established. The following summary sets out the current situation in each State and Territory. In each, abortions are performed in public hospitals and (except in South Australia) by private practitioners.

New South Wales

There is no legal requirement for more than one doctor's opinion or as to the place in which terminations may be performed. Abortions may be performed on social grounds. There are private practitioners, public hospital services and specialist private abortion clinics.

Victoria

The legal position is similar to NSW. There are private practitioners, public hospital services and one private abortion clinic.

South Australia and Northern Territory

Abortion is authorised to avoid a greater risk to the physical or mental health of the woman. The termination must be performed in an approved hospital on the opinion of two medical practitioners.

Australian Capital Territory

The law is assumed to be as in NSW. Abortions are performed by private practitioners or in public hospitals after approval by a hospital committee. The panel, or 'Abortion Committee', services both Woden Valley and Canberra hospitals, and meets weekly. It does not see patients but determines whether the legal requirements are met. Women are referred by their own doctors or from a clinic to a gynaecologist. Few cases are refused at present. Many doctors and the Abortion Counselling Service bypass the 'Abortion Committee', which was originally seen as an obstacle, and most cases are referred to clinics in Sydney. There are no public outpatient gynaecology departments.

Queensland, Western Australia and Tasmania

The grounds for abortion are restricted; abortions are performed by private practitioners in public hospitals.

178. Many Queensland women travel to Sydney to have abortions at one of the private clinics. Women from the ACT also travel to Sydney. The Preterm survey of 1007 patients, in 1974, showed that six women also came from Victoria, South Australia and New Zealand.¹⁰³ Tasmanian women sometimes travel to Melbourne for abortions.

179. Many of our comments have general application to the whole of Australia, but differences in law and practice mean that this is not always the case. They also mean that our conclusions and recommendations may apply differently in different places.

180. The main methods of termination of pregnancy are set out at Annexe IV.M. The relative safety of different methods at different stages of pregnancy is an important aspect of the provision of services.

Abuses in abortion practice

181. Many of those who submitted that abortion laws should be liberalised argued that this was necessary to overcome the many abuses which have occurred in abortion practice and which led to the death or injury of many women. It was said that laws restricting or forbidding abortions do not prevent abortions and that open access to abortion was necessary in order that abortions be carried out in properly equipped facilities by trained personnel under public scrutiny, rather than in improvised, illicit premises by entrepreneurial abortionists whose mistakes and malpractices are hidden from the public eye.

182. Most abortions are now conducted in clinics or hospitals and, although it is difficult for the public to observe what occurs in hospitals, there has been considerable scrutiny of the clinics. For example, in Sydney, Preterm has a medical advisory board and Population Services International an advisory council to review medical procedures and help maintain standards.

183. This is a recent development, however. As recently as the 1960s abortions were performed for the most part in private rooms, by people who were abortionists and not always doctors, whose medical practice was unscrutinised or ignored by the medical profession and the public, and whose methods were tailored to the illegality and clandestine nature of the procedure, rather than to the safety of the patient. This situation was fully documented in the evidence the Commission received and is illustrated below.

184. Many of the abuses complained of occurred in the 1960s and early 1970s, when abortions were not easily available, and do not apply equally to all States.

185. We have not investigated specific allegations to determine their truth or otherwise. It is obvious that we would attract many submissions alleging malpractice and few about proper practice. The stories we have heard are one-sided and several of them are taken from one submission which is confidential. Nevertheless, taken as a whole, we consider that they represent a general picture of the kind of abuse and malpractice which can occur and which may still occur in some places. These abuses occur because, despite the law, many women need and will seek abortions, and because some doctors are prepared to exploit that need and take advantage of the need to act covertly.

186. We stress that doctors who abuse the system are a minority; many doctors have acted responsibly and provided a reasonable service within the inherent difficulties created by the uncertainty of the law. It is the opportunity for abuse which is under attack.

¹⁰³. Snyder & Wall, p. 19. The numbers from Queensland and the ACT were twelve and thirty-nine respectively.

187. The catalogue of abortion abuses illustrates what can occur when legal restrictions are imposed, and helps to determine the criteria for a properly organised and efficient abortion service. The main abuses are the following:

- unsafe and dangerous procedures; lack of adequate facilities and expertise
- delay in confirming pregnancy, deciding upon and carrying out termination
- overcharging
- lack of follow-up procedures and contraceptive services
- failure to provide counselling

These abuses could not be overcome because the client was unable to assume the role of a critical consumer and complain about any aspect of procedure for fear of being unable to obtain an abortion. In the case of hospitals, the woman who could not afford to pay a doctor had little or no choice.

Unsafe procedures; lack of facilities and expertise

188. A typical complaint was about dirty, unhygienic premises. Others concerned the use of dangerous methods of abortion, such as inserting something into the uterus and sending the patient away to miscarry elsewhere.¹⁰⁴

189. A respondent to the Commission's 'unwanted pregnancy phone-in' said:

At the abortionist's rooms I felt I was treated terribly. It was a gruesome, dirty room in a dirty street. I had it done at the abortionist's (brought on) and the actual miscarriage occurred in a hotel room . . . I felt very sick for a long time, and emotionally upset. The whole thing was so sordid and horrid.

Another complaint was that abortionists operate without anaesthesia of any kind, thus increasing the risk of cervical shock.¹⁰⁵

190. In the 1960s and early 1970s, abortion services were considered illegal. Dubious practice and malpractice, moreover, extended in some cases beyond the procedure itself to the services that should have accompanied the operation. It was submitted, for example, that pregnancy tests and blood tests were often neglected or alternatively over-used as a means of making money.¹⁰⁶

191. Other tests which should have been performed were sometimes neglected; for example, the crucial blood test to detect women with Rh-negative blood type who require an injection so that antibodies created by the aborted pregnancy cannot affect future pregnancies.

192. Another prerequisite of safety in abortion is the use of skilled staff—the doctor, the nurse, the anaesthetist, and the person who prepares and sterilises equipment. In the 1960s this was not always the case:

Dr . . . was less avaricious and less exploitative than most. Yet he preferred to employ unqualified women because trained nurses asked too many questions and were hard to fit in with the routine that the illegality of the service imposed.¹⁰⁷

The same submission mentioned that anaesthetics were sometimes administered by an assistant who may or may not have been a qualified nurse.

193. Another abuse complained of was the termination in the second trimester using first trimester procedures, or using the more dangerous second trimester procedures

104. Submission 210, WEL, Victoria.

105. *ibid.*, also evidence from 'unwanted pregnancy phone-in'.

106. Submissions 210, WEL, Victoria; C792, confidential.

107. Submission C792, confidential.

without hospitalisation. A submission referred to a case which occurred in 1973 in which it was alleged that a woman had been sent home after labour was induced by amniotic replacement, when she ought to have been kept in hospital.

She was still pregnant. She had been subject to crude interference and was in labour for 24 hours, requiring several pints of blood. An existing infection flared up and the girl was in a critical condition for some time. Her total expenditure for the abortion included \$200 for interference, referral and two psychiatric opinions.¹⁰⁸

194. This allegation supports our view that all abortion services should be open to scrutiny. When abortion is illegal, there is no incentive to use up-to-date methods, to improve medical skill or to keep informed. Communication with other members of the medical profession becomes difficult. Access to hospital beds, for second trimester procedures in case of emergency, cannot be arranged. Even though the abortionists may be known, their activities are not scrutinised and the medical profession may neglect to take action even when examples of gross malpractice are forced upon their attention.

Delay

195. If an abortion is to be performed it should take place in the first trimester, and thus incur the least risk of morbidity and mortality to the patient. In the past (particularly prior to the opening of the abortion clinics) a number of factors militated against this occurring. A number of hospitals operated quota systems whereby only a limited number of patients were permitted to see the doctor, each clinic day, and be considered for an abortion. When the quota for the operating schedule had been filled, the rest were simply turned away. This resulted in people waiting from one week to the next to try to get into the clinic, or in their shopping around from one hospital to another, sometimes without success.

196. Secondly, since abortion was of dubious legality, a referring GP might not know where to send a patient. Consequently many people wasted time and were delayed by consulting gynaecologists, psychiatrists or GPs who were opposed to the operation. This also occurred within the O&G clinics run by some hospitals, where some gynaecologists were opposed to abortions.

197. Thirdly, because hospitals do abortions on an inpatient basis, women requesting abortions had to wait for beds. In some cases, the shortage of beds for this procedure meant that patients whose pregnancies might have been terminated immediately by a first trimester procedure were forced to wait some weeks when a second trimester procedure was required with increased risk.

198. Fourthly, delays occurred and still occur because people do not know where to go to obtain an abortion. Abortion services may not advertise. Much time may be lost in consulting other people who do not know, or who are unwilling to refer on principle.

199. The Commission was told of numerous instances in which women had been delayed by one or more of these factors:

I was referred by my doctor to a gynaecologist, who refused abortion. So my doctor sent me to . . . hospital—more delay, and they frightened the life out of me about safety and killing the child . . . I also went to the FPA, had a very long wait, but they were fantastic, rang a doctor, arranged an appointment the same day. I went there and was done straight away.¹⁰⁹

108. *ibid.*

109. 'Unwanted pregnancy phone-in'.

200. In another case a woman had to wait one week for a pregnancy test at the hospital, a further week for a consultation with a psychiatrist, another week to see a panel of doctors. By then she was 10 weeks pregnant and was told an abortion was too dangerous.¹¹⁰

201. A woman who was advised to go off the pill suspected pregnancy but was advised she was not pregnant. Her doctor arranged a consultation with a psychiatrist 10 days later. An abortion was not given. Another abortionist refused, as the pregnancy was too far advanced. She attempted suicide and was put in a mental hospital.

In September 1965, 13 weeks after begging my doctor to do something, I had my 20-week pregnancy terminated. After the operation I found that I had been given a complete hysterectomy. I was given no explanation for this and no psychological follow-up.

I hope that no other woman has to live through a similar experience.¹¹¹

202. In other cases it was alleged that abortions were refused by hospitals without explanation and despite the social circumstances of the woman concerned.¹¹²

203. We also received complaints that medical practitioners avoided telling women they were pregnant, or told women that they were far more advanced in pregnancy than they were, in order to prevent them from having an abortion. A similar complaint concerned the discrepancies between doctors about length of gestation, suggesting lack of experience by some of them.¹¹³

204. Many of the delays noted above could have been avoided if the hospital, or other service consulted by the woman, had been organised in such a way as to undertake all the tests and consultations at one time. An important criterion for an abortion service is provision to minimise delay. This includes the rostering of only those gynaecologists and nursing staff who are willing to recommend or undertake abortions.

Overcharging

205. An abortion in an abortion clinic in Australia today costs from \$100 to \$140. Less than 10 years ago, however, women were paying considerably higher fees. The high charges did not guarantee the quality of care they were to receive. We received reports that some doctors are still able to exploit women's ignorance of available facilities and charge high fees.

206. The way in which patients are charged by the doctor can affect their claim for benefits. For example, a high all-in price might be justified on the basis that it is necessary to cover testing, surgery, operating theatre and after-care. Unless these items are listed separately, however, medical benefits cannot be claimed. Further, theatre fees and specialist anaesthetist fees are all charged at full rates but are not allowable unless the theatre is registered and the anaesthetist qualified, which is not always the case. The pricing system of some doctors was said to be exploitive as it depended more on what the patient was able or willing to pay.¹¹⁴ We repeat that we are speaking of only a minority of doctors.

207. Another abuse is that the abortionist may demand payment prior to the operation, which is the reverse of the usual system. A further complication is that the patient may not be given a receipt. It is claimed that this practice still occurs in the case of some doctors, even where the abortion is within the legal ruling or thought to be so; the woman may be uninformed or lack the confidence to ask.¹¹⁵

110. Submission C528, confidential.

111. Quoted in Submission 73, Jo Wainer.

112. Submission 619, Abortion Law Repeal Association, NSW.

113. *ibid.*

114. Submission C792, confidential.

115. *ibid.*

208. The failure to give a receipt, which can be used to obtain medical benefits, prevents the client from observing the discrepancy between the fee paid and the standard fee for the service. It is alleged that in some cases fees were charged for tests which were not performed or were unnecessary.

209. It was claimed that there have been abuses by pregnancy testing services and other referral services¹¹⁶, for example that a positive result would be given falsely or that the referral service would receive a 'kickback' payment.

210. The practice of referral for a second opinion of another medical practitioner or a psychiatrist persists in NSW and Victoria, despite the Levine and Menhennit rulings which require only one doctor to be satisfied as to the need for the operation. Fee splitting was alleged. The system of second opinions does not appear to safeguard the patient since she must satisfy the person to whom she is referred of her need for an abortion rather than discuss her problem and receive counselling. The submission of the Australian and New Zealand College of Psychiatrists quoted an article putting this view:

The consultation is unprofessional and hypocritical, and the role of the psychiatrist in helping the woman to understand her own difficulties, weaknesses and assets, and to arrive at a reasonable and ordered solution to her problem, is impossible.¹¹⁷

Lack of follow-up services

211. A number of respondents to our 'unwanted pregnancy phone-in' reported that they had had an abortion without any provision for follow-up in case of emergency, for routine checks after the operation or for contraception:

I felt like a component on an assembly line—I paid my money, and got six iron tablets. There was no follow-up.

It was all very secret and I was frightened we'd be raided . . . I was told if there were any problems afterwards he didn't want to know about it.

212. It is clearly an important function of abortion services to provide contraceptive counselling, and to encourage the patient to use contraception. This is more successful if the contraception is provided as part of the service rather than by sending the patient elsewhere, even to another clinic on a different day at the same hospital. It is also important that abortion services accept responsibility for the operation performed. This involves maintaining a 24-hour telephone or casualty service for emergencies and being willing to see patients for their post-operative checks.

Disapproving attitudes and lack of counselling

213. The Commission received a number of complaints, many of them of recent origin, about the atmosphere in which a consultation for abortion had occurred. In some cases the doctor to whom they were referred was discouraging or disapproving, even when the termination was decided upon and carried out.¹¹⁸

After the termination I felt very sad; the gynaecologist gave me a bad time at his rooms, with horrid words and attitude. I feel the sort of talking to that I received is not deserved by anyone.¹¹⁹

214. People who present with a request for an abortion are entitled to the same courtesy in consultation as patients of any other medical service. A number of abortion services take steps to ensure that their clients are treated with sympathy and

116. *ibid.*

117. S. Gold, 'Abortion morality and psychiatry', *Panacea* 2, 1 & 2 (1969), pp. 4-6, quoted in Submission 785, ANZ College of Psychiatrists.

118. 'Unwanted pregnancy phone-in'; Submission 210, WEL, Victoria.

119. 'Unwanted pregnancy phone-in'.

understanding. Trained counsellors should be available to women who wish to review their situation before coming to a decision. A woman who had attended such a service commented to the Commission:

I had an abortion at a private clinic. I was treated extremely well. I felt how simple it was—no obstacles . . . They explored my feelings about it thoroughly. After the termination I felt not too bad physically, and relieved emotionally, no recrimination.¹²⁰

Criteria for abortion services

215. We have based our criteria upon a consideration of these abuses and upon an examination of our submissions and evidence and some consultation with doctors. The criteria are as follows:

Proper medical procedures, facilities and expertise

216. This would include the use of the latest and safest methods, appropriate tests and safeguards, skilled staff, aseptic conditions, appropriate anaesthetic and resuscitation equipment and adequate hospital back-up. It is essential to establish beyond any doubt that the patient is pregnant. The patient should be examined for physical abnormalities, the period of gestation and the presence of any infection. An Rh blood grouping test should be performed. The safest method of termination of the pregnancy, according to the length of gestation, should be used by practised medical personnel assisted by trained support staff. Our study of the consequences of abortion shows that level of skill and method are significant factors affecting morbidity and mortality. Appropriate equipment should be used, properly prepared and sterilised. If general anaesthesia is used, a trained anaesthetist should administer the anaesthetic, and, for both local and general anaesthetics, equipment should be available for emergency resuscitation. An abortion service should be part of, or in the vicinity of, a large public hospital to which its patients can be admitted in case of emergency. If it is to provide second trimester terminations, the service must have access to hospital beds and facilities.

The avoidance of unreasonable delay which may prejudice the safety of the abortion

217. An abortion should take place in the first trimester to incur the least risk of morbidity and mortality.¹²¹ An abortion service should be so organised as to minimise the delay between first presentation, confirmation of pregnancy, decision to terminate and the performance of the abortion. Free access to information about services is important.

Reasonable fees for the full range of services

218. An abortion service should provide for a reasonable and competitive fee, the full range of tests, counselling and procedures that the patient requires.

Follow-up services

219. These would include contraceptive information and advice, particularly for women at special risk, as well as a 24-hour telephone service for emergencies and post-operative checks.

Proper counselling before and after; a friendly atmosphere is important

220. There is a need for counselling, preferably at the same place where the medical consultation takes place.

120. *ibid.*

121. See Commission research report, no. 2, at Annexe IV.P.

General comments

221. To ensure that these criteria are fulfilled abortion services should be open to public scrutiny. The public should be able to see that proper practices are observed. This is a key factor in removing legal restrictions on the performance of abortions. It is essential for improving skills and ensuring the best techniques necessary to minimise risks.

222. Other important issues not so far mentioned are accessibility of services and the place of abortion services in the general structure of health services. These issues are closely connected because the general health services offered by hospitals or community health centres may be better placed to offer services easily accessible to a large proportion of the population than specialist and separate clinics. We return to this issue after discussing existing services.

223. How well do current abortion services measure up to the criteria outlined above? The pattern of service varies, and depends largely on the legal provisions in States and Territories. We compare the services provided by clinics, practitioners and hospitals, and consider whether there is any need to regulate services.

Abortion clinics

224. Three abortion clinics, one in Melbourne and two in Sydney, have a number of special characteristics in common: they are 'free-standing' establishments providing a specialised service; several doctors work co-operatively to provide the medical service; a number of other personnel, such as nurses and counsellors, are employed to provide additional services. The client of the service is charged standard fees.

225. Two clinics, Preterm and Population Services International, are in Sydney. They employ some salaried staff; others are paid on a sessional basis. PSI has two locations in Sydney and, at the time of preparation of this report, has announced plans to establish a clinic in the ACT. The Fertility Control Clinic in Melbourne is a private practice and the doctors are paid a fee for service. The Fertility Control Clinic operates in a very similar manner to the other two clinics. The Planned Parenthood Clinic in Prahran has not been included in this group. This service is a small private group practice at which counselling is provided as a voluntary service by the Prahran Womens Action Group.

Range of services

226. These abortion clinics provide, in one location, all services necessary to a client seeking a legal termination of pregnancy in the first trimester. All three provide pregnancy testing; counselling on the decision; the operation itself; contraception; haematology (blood grouping) on the premises; identification, treatment or referral for sexually transmitted diseases; papanicolaou smears and breast examinations. In the case of Preterm a significant number of women attend for contraceptive advice or sexual counselling, quite apart from abortion patients. Two of the clinics (PSI and FCC) provide male and female sterilisation operations, and second trimester operations; one does operations to 16 weeks on the premises; the other uses the facilities of an adjacent hospital and performs later terminations using the two-stage method.

227. All three provide a 24-hour emergency telephone service, and clients either return to the clinic for a check and contraceptive service or return to their own doctor. The entire visit to the clinic takes only a few hours, including a wait of an hour or so after the operation. The majority of Preterm patients are referred by doctors; the balance are from FPAs, womens health centres, with a few coming directly.

Method

228. At Preterm, abortions are performed by the vacuum aspiration method normally up to 10 weeks. The waiting time for an appointment is 10–14 days. Pregnancy testing is usually done beforehand; but it can be done on the day of attendance. All other testing and examination and the operation itself are performed on the day. Women unable to obtain an appointment are referred to other services.

229. PSI uses the vacuum aspiration method up to 16 weeks. Services are performed on the day of appointment. This clinic also offers the services of menstrual regulation (before diagnosis of pregnancy).

230. The Fertility Control Clinic uses the vacuum aspiration and curettage method for early terminations, up to 12 weeks. For pregnancies between 12 and 16 weeks the method used is ovum forceps and vacuum aspiration. Late terminations are performed by saline induction.

Fees

231. The cost of a termination in the first trimester at each of these clinics is as follows:

Preterm (Sydney) (January 1977)

Basic fee for consultation, procedure and post-operative check at 10 days: \$90.00
(minimum refundable amount \$77.75)

Pregnancy test, if required: \$6.90
(refundable)

Clients pay and then obtain their own refund. Preterm bulk-bills Medibank patients who cannot raise the money; women who cannot pay, or who are dependants and cannot use their private insurance, are sometimes treated free. Patients do not buy drugs at the clinic but are issued with a prescription to be used if necessary.

PSI (Sydney) (February 1977)

Basic fee for consultation, procedure and post-operative check at 3 days: \$111.15
(includes general anaesthesia)

Pathology \$36.40
(both amounts are refundable)

Additional patient costs are for drugs purchased at the clinic on prescription or for the IUD if required. Medibank patients are bulk-billed and privately insured patients who are dependants and unable to use their private insurance are treated free. Other patients obtain a full refund except for pharmaceutical items.

The two-stage procedure costs \$180 plus one or two days hospitalisation at \$44 per day, and pathology as above (mostly refundable).

The Fertility Control Clinic (Melbourne)

Basic fee for consultation, procedure and post-operative check:

General anaesthesia \$88.00

or

local anaesthesia \$71.00

Pathology—average \$22.00

These are the bulk-billing rate fees to which the optional 15 per cent to bring the fee to the common fee-for-service level has not been added.

The clients are bulk-billed, charged or treated free on the same basis as those of PSI.

The patients in all cases may have to pay for contraceptive items.

The fees do not have to cover an overnight stay and are mostly refundable.

Staff

232. Each clinic employs between seven and nine doctors and between four and nine nurses on a sessional basis. The major variation between clinics is in the number of counsellors employed. Preterm employs twenty-one, PSI nine and the Melbourne clinic four. PSI also have two psychiatrists, two psychologists and two social workers to whom they can refer patients for consultation.

Counselling

233. The main reasons for the differences in the number of counsellors are the philosophies of the organisations and the type of anaesthesia used.

234. Preterm, which uses local anaesthesia exclusively, employs counsellors not only for the purpose of reviewing the decision with the patient, but also to explain the stages of the procedure and what sensations can be expected. The counsellor accompanies the patient into the procedure room to offer emotional support. On any given day there are ten counsellors for about thirty patients.

235. Because they use general anaesthetics, the other clinics have fewer counsellors. These clinics also see more patients (8000 each, in 1975, compared with Preterm's 4000), spend less time on each operation and see more interstate clients. PSI, for example, handles most of the referrals from Children by Choice, a Brisbane agency. Nearly all of these clients have been counselled in Brisbane. Some other agencies also counsel clients before referral.

236. The matter of counselling has been an issue for dispute as some regard it as unnecessary or an infringement of the patient's civil rights. The law requires the doctor, however, to be satisfied that the patient's circumstances are such that continuation of the pregnancy may be more harmful than its termination. Even without legal restrictions, the doctor should weigh up the comparative situation and also check whether the patient is being pressured into the operation by circumstances or by family, husband or partner. As this may be time consuming, most clinics use counsellors to assist the doctor in ascertaining the patient's situation while taking a history and advising on contraception. Patients who have fully considered their situation may not need counselling as such; but the patient under pressure or one psychologically disturbed must be recognised and counselled or referred prior to operation, either by the counsellor or the doctor.

237. The functions which counsellors need to perform include the following:

- (a) to recognise those women who are being pressured into an abortion, and to counsel them about their decision;
- (b) to advise clients of their rights and explain the alternatives available to them, and to tell them about other agencies able to assist;
- (c) to assist clients to choose a course of action;
- (d) to inform clients about contraception and how it may be obtained;
- (e) to inform clients about the operation, and possible side effects;
- (f) to provide emotional support for clients undergoing the operation;
- (g) to answer questions.

238. The provision of adequate counselling is an essential element in an abortion service. At present, counselling services provided by clinics are paid for out of the fees

charged for medical services. This is because counselling services provided by non-medical personnel do not attract medical benefits. This is unfortunate, because the woman often has much need of counselling. If financial difficulties arise, the clinic might have to reduce the number of counsellors. The alternative of Health Program Grants might allow for greater flexibility in use of personnel, but does not necessarily provide an assured source of income for the future. Without entering into the debate between fee for service and direct funding, we consider that the need for counselling is such that the government should subsidise the cost of training and employing counsellors at abortion clinics, including hospital abortion clinics.

Procedures, equipment and training

239. The activities of the clinics are more readily open to scrutiny than those of private doctors and hospitals, and this is an important factor in maintaining standards. They have an added incentive to keep up to date with methods, equipment and training, to remain competitive and minimise costs. Specialisation implies that the doctors are skilled and practised, an important factor in reducing morbidity. Low morbidity rates at the existing clinics were demonstrated in the data collected for our survey of the consequences of abortion.

240. The clinics do not all offer the woman a choice between general or local anaesthetic. At PSI and FCC, where general anaesthesia is available, few women elect to have local anaesthesia. It is claimed that this is the patient's free choice. It should be noted, however, that the costs of installing equipment and of paying a qualified anaesthetist are high and need to be covered by full use of the service, and that the operation can be performed faster under general anaesthetic.

241. Preterm, on the other hand, uses local anaesthetics exclusively, considering that this involves slightly less risk to the patient. Women who want general anaesthetic are referred elsewhere.

242. In our view it is important that women should be able to exercise a choice. For this they need to be informed of the procedures available at different clinics and the scope for choice available at each. The clinics should refer to other services where appropriate to ensure that the choice can be effective.

General comments

243. There are advantages offered by the free-standing clinic, including the following:

- (a) medical and other staff are not opposed to abortion; staff attitudes are supportive rather than disapproving;
- (b) medical staff are able to develop expertise in their special field, thereby minimising the risks of the operation;
- (c) counsellors are available and are able to develop special skills.

Not all clinics offer the same standard of service. We were concerned to know whether there were any criticisms of their services. Each clinic was visited by at least one member of the Commission.

244. So far as Preterm is concerned, we received no complaints about the service offered, and we were favourably impressed by the physical premises, atmosphere and attitudes of all staff. Some women who phoned the Commission during the 'unwanted pregnancy phone-in' did so in order to express their satisfaction at the treatment they received at this clinic. At February 1977, Preterm was unable to deal with the number of requests for appointment. The waiting time was 10-14 days, patients who could not be given an appointment being referred on to other services.

245. We visited the Arncliffe clinic of PSI. Our main impression was that there was much less emphasis on counselling and on maintaining a relationship between counsellor, patient and doctor. As we have mentioned, some women have already been counselled before attending the clinic, and the operation is carried out under general anaesthetic. We have no way of assessing the medical standards. The approach appeared to be more impersonal and commercially oriented as compared with Preterm.

246. Our impression of the Fertility Control Clinic in Melbourne was that the staff were friendly and supportive, but that the premises were overcrowded, and this did not lend itself to as relaxed an atmosphere as one would have wished.

Private practitioners

Occasional abortions

247. Among the more than 7000 general practitioners and 716 gynaecologists in the country, there are some who occasionally provide abortions for their patients. We have not been able to ascertain how many doctors this involves, although these doctors apparently account for some thousands of abortions performed in Australia each year. Many of these abortions are performed in hospitals and may not be recorded for medical benefit purposes or on operating schedules as abortions, but rather as dilatation and curettage operations. It is possible, therefore, that the extent of this source of abortion service has been underestimated.

248. One of the problems with this service is that it is practically invisible. We received a number of accounts of this kind of abortion in the 'unwanted pregnancy phone-in'. Some women had been well treated, some punitively, and it is difficult to know what kind of service is being rendered. Our research into the consequences of abortion shows that the incidence of morbidity and the risk of death from abortion is likely to be higher when the operation is performed by practitioners who do not use the procedure frequently (see Annexe IV.P). Where the operation is performed as a dilatation and curettage (D & C) it seems that the practitioner is unlikely to be using the vacuum aspiration method which has a lower morbidity rate than D & C. Another aspect of private practice is that it is unlikely that the practitioner uses trained support staff to counsel the patient about this operation. The quality of counselling received will therefore depend exclusively on the doctor.

249. Our view is that abortions are best performed by persons practiced at this operation. With more open provision for such services, the need for private practitioners to perform these operations occasionally should diminish. This is particularly important in the case of second trimester operations, which require special skill and technique and should not be performed on an occasional basis by private practitioners.

Abortion specialists

250. There are at least twenty doctors who, according to inquiries by the Commission, are known by more than one source to be obtaining a regular income from doing a minimum of 13 000 abortions each year. These abortions are performed either in their rooms or in small private hospitals. Most of these doctors are in NSW and Victoria. In Western Australia most abortions are performed by private practitioners.

251. Since doctors in this category are performing abortions on a regular basis, perhaps up to forty per week, the likelihood that they are skilled is increased. We have no information about the methods used by these doctors, although most are believed to be using vacuum aspiration followed by curettage for first trimester terminations,

and some are using saline for second trimester operations. Some are using general anaesthetics, and some local. Some patients are referred after having been counselled. Some doctors provide additional counselling. In Melbourne one private practice, called the Planned Parenthood Clinic, charges the refundable fee for service and provides a service similar to the clinics.

252. Many of the abuses mentioned earlier in this report were laid at the door of the abortion specialist. There appear to have been changes in practice in NSW and Victoria with the emergence of clinics. The abortion clinics have provided the private practitioner with such competition that he has been forced to conform to many of the standards maintained by the clinics in order to continue to attract referral. For example, within months of the opening of Preterm, in 1974, the fee for an abortion in Sydney had dropped from around \$80-\$200 to the \$50 Preterm was then charging. Since the clinics opened private practitioners have had fewer patients, possibly because more women are referred directly to the clinics.

Comments and conclusions

253. The disadvantages of private practitioner abortion services are as follows:

- (a) Because of the smaller number of patients seen, private practitioners do not usually employ a counsellor.
- (b) In States in which abortion laws are not interpreted liberally, or in which abortion practices are not open, the absence of locally based clinics makes it easier for old style abuses to continue.
- (c) Because so many first trimester abortions are now performed in clinics, private practitioners in NSW and Victoria are receiving more referrals than before for the more difficult second trimester procedures. In some cases, these operations are being performed in private rooms without adequate back-up facilities in case of emergency.

254. One improvement, however, is that abortion clinics are able to assist patients whose pregnancies have passed the first trimester stage by referring them to private practitioners and other services able to perform second trimester operations. In this they are able to exercise some choice. It is important, however, that clinics and hospitals assume further responsibility in respect of second trimester abortions to ensure that these difficult and more dangerous procedures do not remain the province of unscrutinised practitioners.

Public hospital services

255. Women have abortions in hospitals as private or public patients. The private patient's care is a matter for the woman's doctor and has been dealt with in the previous section under 'private practitioners'. Abortions are performed for 'public patients' in public hospitals in all States and Territories, though the ease with which an abortion may be obtained and the number performed depend on the law in force, and on the attitude of the doctor and staff. In South Australia and in the Northern Territory, abortions may be performed only in an approved hospital. We were told it is very difficult to get an abortion in a public hospital in Queensland, Western Australia and Tasmania.

The survey of admission procedures

256. We investigated (by means of a questionnaire) the abortion service provided by public hospitals.¹²² A sample of public hospitals was taken which included: all the major public hospitals with obstetric and/or gynaecological units in the capital city of

122. Commission research report, no. 3, 1976.

each State except Queensland (where only one hospital co-operated); a random sample by bed size of the larger remaining public hospitals in each State except Queensland¹²³; and, for the purposes of comparison, one major Roman Catholic obstetric or womens hospital in NSW, Victoria, South Australia and Western Australia¹²⁴; one large religiously affiliated private hospital; and one large public psychiatric hospital.

257. The aim of the study was to discover to what extent public hospitals were seeing women requesting a termination of pregnancy and performing the operation, and whether or not any particular organisational arrangement had been made to cope with such factors as staff hostility to the operation, the psychological well-being of the patient and the skill and practice of the medical practitioners performing the operation.

258. We considered the results of this survey and assessed the abortion service of public hospital clinics by the criteria named above: proper medical procedures, absence of delaying factors, moderate fees, provision for follow-up services and friendly atmosphere. The data are available for study, but have not been fully written up.

Medical procedures

259. In all, fifty-two hospitals responded to the questionnaire. Four Roman Catholic hospitals and three public hospitals did not perform abortions. One private denominational hospital, one public psychiatric hospital and forty-three public hospitals did perform abortions. Only one of the Roman Catholic hospitals stated that they would refer a patient requesting an abortion to another hospital, whereas all three of the public hospitals not performing abortions stated that they referred patients to a public or private hospital and, in one case, a private doctor.

260. The forty-four public hospitals performing abortions had performed 6978 abortions in 1975, with one hospital performing only one abortion, and one hospital performing 1000. Some of the hospitals acknowledged their figures to be an understatement. One medical superintendent wrote that the twenty-five abortions mentioned as performed at his hospital probably represented 10 to 15 per cent of the actual number of abortions performed there.

261. The grounds for termination at most hospitals were medical and psychological. Only fifteen hospitals stated that abortions were performed at their hospital on socio-economic grounds. Fifteen other hospitals stated there was no hospital policy, and the matter was left to the discretion of the individual doctor. There were indications that the application of these grounds was not confined to the States of NSW and Victoria, but extended to SA, WA and Tasmanian hospitals.

262. The most efficient and least dangerous method of terminating a pregnancy in the first trimester is by vacuum aspiration: a total of 1170 were recorded, with a range between one and 228. Hospitals were asked how many vacuum aspirations had been performed in the 3 months prior to the receipt of the questionnaire. Twenty-three said none had been performed; eleven of these did not use the vacuum aspiration technique (including six in NSW, three in SA, one in WA and one in Tasmania). All but two of these hospitals were outside the capital city areas. Thirty-six of the forty-four

123. The public hospitals in each State were approached after consultation with the Premier's Department and the Health Department of each State. In Queensland the Commission was permitted to approach two major public hospitals only, one of which replied.

124. There is no large Catholic maternity hospital in the ACT and Northern Territory. In respect of Queensland and Tasmania, the Commission was guided by the wishes of the respective Departments of Health.

public hospitals performing abortions also stated that many of these were still done by D & C operations; only five of the major city hospitals stated that D & C terminations were no longer being done.

263. We note that a significant proportion of first trimester terminations are still being performed in hospitals by the D & C method. In this respect, the country hospitals do not seem to have kept up with the advances in technique used in most city hospitals and abortion clinics.

264. Of 159 second trimester operations in the previous 3 months, eight hospitals had performed only one operation, one hospital had performed sixty-nine, and twenty-nine hospitals had performed none, although all forty-four hospitals stated that these were sometimes performed.

265. There are a number of methods of terminating a pregnancy in the second trimester, and some dispute as to the relative safety of these methods. Amniotic replacement methods can involve use of prostaglandins, saline solutions and urea. Of the three, prostaglandins are considered the safest; however, distribution of prostaglandins is limited and in our survey these were being used in only six hospitals in major city areas. Saline solutions were being used in eleven hospitals, urea in six, and twenty-seven public hospitals reported that, at their hospital, hysterotomy (small caesarian section) was used for second trimester terminations. Ten hospitals reported that hysterectomies were also being performed for this purpose. The survey did not inquire into the reasons why hysterectomies were being used to terminate pregnancies, and it must be allowed that, in most cases, a hysterectomy would be warranted on other grounds. Nevertheless, we are concerned that hysterectomies may be being performed where sterilisation is not medically necessary. It is our view that sterilisation should not be made a condition of an abortion.

266. We are also concerned that, at twenty-seven public hospitals, hysterotomies are still being performed to terminate pregnancy. The death rate for this procedure is much greater than that for amniotic replacement procedures, and the consequences for future childbearing are sometimes serious due to the potential for rupture of the uterus. It seems probable that this method continues to be performed because medical staff at some hospitals lack the expertise to perform amniotic replacement procedures. In our view, patients at such hospitals should be given the option of referral to a hospital at which safer procedures are available. Efforts should also be made to train staff in these methods.

267. We obtained no information through this survey about the tests and screening procedures given to abortion patients; however, hospitals have the facilities for all of the tests provided by the abortion clinics. All hospitals should screen patients not only for blood type but also for venereal diseases and cervical cancer. A few hospitals indicated this was already a routine procedure.

Morbidity rates

268. Our survey of the morbidity of abortion revealed a higher rate of morbidity for hospitals than clinics. A different and cruder measure was used in the survey of hospitals. The hospitals were asked to record the duration of stay in the hospital for vacuum aspiration patients in the last 3 months. Most of the patients stayed in hospital the day of the operation only, or one night, and this was standard procedure. Five hospitals preferred patients to remain in the hospital for 2 nights. Of 1170 vacuum aspiration patients at public hospitals, however, thirteen stayed in hospital for 3 nights, seventeen for 4 nights, five for 5 nights, seven for 6 nights and three for 7 to 14 nights. Some of these patients may have remained for reasons not connected with the abortion.

However, if forty-five patients remained because of complications of the abortion, this yields a morbidity rate of 3.8 per 100 patients. No deaths were recorded. The data also indicate fifty-two patients returning to hospitals as patients because of complications. Although the combined figures of forty-five and fifty-two patients yields a complication rate of 8.3 per 100 patients, the two categories of patient may overlap. A minimum figure of fifty-two patients with complications sufficient to warrant hospitalisation yields a morbidity rate of 4.4 per 100 patients.

269. It was difficult to do a similar analysis for second trimester terminations in public hospitals since some of these involved major operations. However, the data indicate that twenty patients stayed in hospital for 7 to 14 days, and one patient for more than 3 weeks. Eighteen patients returned to the hospital as inpatients because of complications. Taking nineteen patients as experiencing morbidity sufficient to warrant hospitalisation yields a morbidity rate of 11.9 per 100 patients.

270. This supports the view expressed earlier that hospitals performing termination of pregnancy operations should train staff in the amniotic replacement methods, and that they should refer patients wherever possible rather than performing hysterotomy and hysterectomy procedures for termination of pregnancy reasons alone.

Medical experience

271. The frequency with which an operator performs termination enhances his skill at this procedure. In a hospital, therefore, where a number of doctors use the operating theatre, several situations may occur. The hospital may refer all patients to doctors who may perform very few terminations. In other hospitals patients see doctors at the outpatient clinic. The operation may either be performed by the specialist on roster, or by visiting specialists. The latter situation gives the best opportunities for improving the skill of the operator, and the best possibility for low rates of morbidity.

272. Excluding the one private hospital, the data revealed that fourteen public hospitals did not have any public outpatient clinics which patients could attend; they referred all patients requesting abortion to private medical officers rooms. In four of the remaining thirty hospitals terminations were done regularly by the same doctors who were appointed to a special clinic for this purpose. In all the other hospitals, terminations were performed by gynaecologists or registrars as part of their regular operating schedules. In five hospitals, doctors' opinions were sought prior to their being assigned to an operating schedule to perform abortions.

273. While doctors may prefer not to spend all their time, or even most of their time, performing abortions, hospitals should be aware of the possible benefits in terms of reduced morbidity which may flow from arranging for abortions to be performed regularly by the same doctors, who may thus develop some expertise. Any reorganisation of procedures should be consistent with our earlier recommendation that doctors who are opposed to the operation should not be selected or required to perform these operations. Similar provisions should apply to the nursing staff.

Intake procedures at public hospitals

274. Before the opening of abortion clinics in Sydney and Melbourne, public hospitals operated a quota system whereby only a certain number of patients were accepted for abortion each week. Our survey revealed that only four public hospitals now operate quotas, three of these in Victoria and one in South Australia. The quotas are for 5, 12, 14 and 18 patients a week. The quota system is usually established when demand for the operation is high and the number of available beds is limited. Abortion services often impose considerable strain on hospital resources, particularly as it is performed as an inpatient procedure. Without some restriction on numbers, overcrowding might ensue, and other gynaecological operations be impeded.

275. In our view a system which requires a quota is undesirable, since it may mean that patients are turned away or that they have to wait or go elsewhere. The quota system would be unnecessary if adequate facilities such as abortion clinics were available. In Sydney a number of public hospitals which used to operate quota systems abandoned this when the abortion clinics opened.

276. Other delays in public hospitals are caused by infrequency of outpatient clinics, requirements for a second visit and shortage of hospital beds. The thirty public hospitals with outpatient clinics may be divided according to whether the decision about the operation was made on the day that the patient first presented, or some days later.

277. Table IV.31 shows the answers we received to the question: 'How long does the initial intake procedure usually take?' (i.e. from the time of first presentation to the time the decision is made).

Table IV.31 Time taken in decision for admission to hospital

| Time | Number of public hospitals with outpatient clinics |
|--------------------|---|
| less than one hour | 6 |
| 1-3 hours | 4 |
| 1-2 days | 3 |
| 2-4 days | 5 |
| 4-7 days | 10 |
| 7 + days | 2 |

278. Hospitals taking more than one hour to achieve the decision require the patient to have a consultation with a second doctor, social worker or psychiatrist. At two hospitals the decision has to be taken by a review board. Patients presenting on the wrong day of the week for the clinic are delayed by having to return some days later. After the decision is made, most hospitals report a 4- to 7-day wait for a hospital bed. At a maximum, therefore, some patients may have to wait for 2 weeks for the time of the operation. A 2-week delay may make the difference between a first and second trimester operation, and may account for some of the hysterotomies being performed, although cases requiring priority are often booked in first. Since some of the abortion clinics and other private practices sometimes have waiting lists of 10 days, it becomes imperative that women seeking abortions should do so as early in the pregnancy as possible.

Fees

279. Public patients at outpatient clinics pay no fees and are no longer subject to a means test. Hospitals without an outpatients clinic sometimes refer abortion patients presenting to the casualty department to private medical practitioners. The procedure varies from hospital to hospital. In some cases, we were told, virtually all the women become private patients as a matter of policy. In other hospitals the patients pay the private medical practitioner for the consultation and recommendation for the operation, but may return to the hospital and have the operation as public patients, paying no fees. In these cases the operations may be performed by staff doctors or, in some cases, the patient may be operated on by the doctor of her choice. In still other hospitals, particularly public hospitals in country areas, the local doctors will see patients as either hospital patients or private patients. Hospital patients do not pay for the consultation. Frequently, in country areas also, hospital patients may see the doctor of their choice. In all cases pensioners are not charged.

280. The question of fees, therefore, arises only with the woman who presents to a public hospital which does not have an outpatient clinic and which cannot refer her to a doctor who will see her free of charge and refer her back to the hospital as a public patient. In such cases the woman becomes a private patient, and must claim a refund for the medical and hospital charges incurred. This means that she has to pay the fee and claim a refund. If she is dependent on another person who pays family rate private insurance, she may not wish that person to know about her operation, and may therefore feel that she is unable to claim a refund. Her position then depends on the discretion of the doctor to whom she is referred, and also on her knowledge of, and the availability of, alternative services. Difficulty in obtaining money to pay fees may result in the operation being delayed.

Follow-up services

281. Our survey inquired whether patients who had abortions in public hospitals were given any contraceptive advice by the hospital. The major finding was that it was not usually hospital policy to provide contraceptive advice but that this decision was left to the individual doctor. There was a significant difference between public hospitals, however, depending on whether patients were using hospital outpatient clinics or being referred to a private physician. Twelve of the thirty hospitals which had outpatient clinics stated that it was the policy of the hospital to provide contraceptive advice to abortion patients, compared with one of the fourteen public hospitals which did not have outpatient clinics for abortion patients. Again, twenty-four of the thirty hospitals with outpatient clinics reported that patients usually received contraceptive advice compared with seven of the fourteen hospitals without outpatient clinics.

282. We are of the view that public hospitals should, as a matter of policy, provide contraceptive advice to patients whose pregnancies are terminated, and should ensure that this advice is given before the patient leaves the hospital and checked later at the follow-up visit to the hospital or doctor. Only two hospitals reported that this advice was given by a nursing sister. Public hospitals should investigate the practicability of trained nurses or contraceptive educators giving this advice. In Sydney the FPA's offer to provide a service to public hospitals was largely rejected.

283. All thirty public hospitals with outpatient clinics held clinics at which abortion patients could attend for post-operative checks. The fourteen hospitals without outpatient clinics did not provide this service.

Referral

284. All but two of the public hospitals stated that patients refused a termination of pregnancy would be referred to alternative agencies for this operation. However, twenty-three hospitals stated that this occurred at the doctor's discretion and was not the policy of the hospital.

Hospital staff

285. Most complaints about public hospitals made to us were about treatment by hospital staff:

. . . [the gynaecologist] made me feel terribly small. He said it was people like me who keep hospital beds full and keep people with emergencies out.

The gynaecologist at . . . was furious because I had been referred from the country. He said 'Why don't they take care of their own patients?'¹²⁵

125. 'Unwanted pregnancy phone-in'.

286. Because people who work in hospitals have a range of views on abortion, there are bound to be some who are opposed to the operation. This ought not to lead them, as it sometimes does, to be offensive. Women who present to hospital requesting abortion should receive considerate treatment.

287. Some of the problems which arise from staff opposition to abortion could be overcome by arranging for abortion patients to be seen at a special clinic and by selecting as personnel for the clinic specially trained staff who are willing to be involved and who can provide continuity of service.

288. Four public hospitals in our sample held special clinics for abortion patients; in two instances, doctors were rostered to attend the clinic. For one of these clinics, the medical superintendent wrote:

There are sufficient specialists in the clinics to ensure that those with fixed attitudes do not interview patients.

In the case of the other clinic, the doctors' views on abortion were canvassed prior to assignment to a roster to interview patients although not to the roster for the performance of the operation. In the remaining two clinics, the clinics were staffed each week by the same personnel.

289. Of the remaining twenty-six public hospitals with out-patient clinics, all stated that patients requesting an abortion were seen at general gynaecology clinics, six stated that they were also seen in the infertility clinic. Although this was justified as an attempt to spread these patients between outpatient clinics, we do not consider this a satisfactory arrangement either for the abortion patients or for the infertility clinic patients.

290. Of the twenty-six hospitals with outpatient clinics, four stated that their doctors were rostered to interview abortion patients. However, at only one of these were the doctor's views about abortion taken into account prior to his being assigned to this roster. In all four hospitals, and in two others, doctors were stated to be rostered, also, to the performance of these operations. At four out of the six hospitals the doctor's views are taken into account prior to his being assigned to this roster. In ten public hospitals nursing sisters are rostered for termination of pregnancy operations, but in only eight of these are their opinions about abortion canvassed beforehand.

Referral services

291. Women in Australia are referred to abortion services in a number of ways: by a general practitioner or specialist; by a voluntary association offering information and, in some cases, counselling or other services; or by a hospital or abortion clinic unable to deal with the particular case. Most women are probably referred by their GP. In the present uncertain legal situation the voluntary referral services provide the much needed service of putting the woman in touch with a doctor, clinic or hospital willing to consider an abortion. The FPA clinics usually provide a pregnancy testing service and arrange referral to an abortion service.

292. In Sydney the FPA, Leichhardt Womens Community Health Centre, and Control provide pregnancy testing and some counselling and refer women to Preterm or other clinics or hospital services. In Victoria, Womens Liberation runs a referral and counselling service. In other States the choice is restricted.

293. In Western Australia the Family Planning Association and the Abortion Law Repeal Association refer patients, after pregnancy testing and counselling, to private

practitioners who will perform vacuum aspirations. They told us that there was little chance of being accepted for an abortion in a public hospital, and that few women travel interstate.¹²⁶

294. The Children by Choice agency in Brisbane provides pregnancy testing and counselling services, and arranges for women to travel to an abortion clinic in Sydney (mainly PSI) on a day return basis.¹²⁷ Two-thirds of the women are referred to them by doctors.¹²⁸ They charge patients a fee of \$3 membership and \$2 for counselling; only members are counselled. Few abortions are performed in public hospitals in Queensland.

295. The Abortion Referral Service in Adelaide organises a voluntary roster system to give advice on pregnancy testing and to refer to a hospital clinic. In the view of the witnesses who gave evidence to us, it is difficult to get abortions in South Australia because of inadequate facilities. They considered that the restriction on advertising meant that many women had no information about available services.¹²⁹

296. In the ACT the Abortion Counselling Service refers women to private clinics in Sydney or Melbourne, and also to private practitioners and to the ACT public hospitals, where abortion has to be approved by a hospital committee. It appears that most women seeking abortion have to go outside the ACT.

297. While we are aware of the potential for abuse in abortion referral services (e.g. kickback payments and fee splitting)¹³⁰ our attention has not been drawn to any such abuses in Australia.

298. It is, of course, particularly important that referral services exercise discrimination in their referral policies and refrain from referring to poor services. Unfortunately the choice in some cases is limited because of the absence of public health service facilities.

299. The question of advertising the services of referral agencies is a difficult one, particularly in the case of those that charge fees. We have not considered the issue in detail. The need for advertising is indicative of the difficulties many women now find in gaining access to services. Womens Abortion Action Campaign has produced a guide to abortion in several languages; it is available at bookshops.¹³¹

Methods of termination

300. It is apparent that not all hospitals are using the most satisfactory methods to keep down the risks of morbidity.¹³² Many, especially those outside the cities, are still using the D & C rather than vacuum aspiration for first trimester abortions. Few hospitals are able to offer the amniotic replacement method for late terminations, despite its apparent advantages for the health of the woman as compared with hysterotomy. Information about the comparative safety of different methods and about the need for skilled and experienced practitioners should be widely distributed, and hospitals should be encouraged to provide training and equipment for the safest methods. Sterilisation should not be a condition for termination of pregnancy.

126. Evidence, pp. 2039 ff, Ms Denise White, ALRA, WA; pp. 2094 ff, Dr Gwen Leavesley, WAFPA.

127. Evidence, pp. 1743 ff, Ms Judy McLeod; see also Rigg, Commission research report, no. 4.

128. Evidence, p. 1745, Ms Judy McLeod, 60–70 per cent was estimated.

129. Evidence, pp. 1388 ff, Marilyn Doley & Susan Higgins.

130. See Lane report, vol. I, para. 452.

131. *'A woman's guide to abortion—why, how, where'* (WAAC, 1975).

132. For a full discussion of the morbidity attached to different methods see Commission research report, no. 2, at Annexe IV.P.

301. Our attention was drawn to the method of dilatation, curettage and use of ovum forceps which is used in the second trimester by a few practitioners in Australia who have specialised in abortion. In their hands, this operation appears to have a low morbidity rate. Further, it avoids the need for the woman to undergo a hysterotomy operation or labour induced by replacement methods. The method has been rejected by some gynaecologists on the grounds of risks of infection and haemorrhage. The amniotic replacement methods are relatively safe and avoid the need for the practitioner to perform a potentially distressing operation; but this may be to the greater discomfort and detriment of the patient who has to undergo labour. We have not investigated this method and there are no statistics available to us about it. A properly conducted audit of the consequences of the curettage plus forceps operation appears to be necessary to evaluate the conflicting claims.

Menstrual regulation

302. Menstrual regulation or menstrual extraction is the same procedure as an early termination by vacuum aspiration, except that it is performed before diagnosis of pregnancy.¹³³ The method is offered by Population Services International in Sydney. The Director, Dr Geoffrey Davies, told us about the method:

This amounts to inducing late periods as fertility control, whether pregnancy is present or not present . . . it has been extensively investigated and it seems to be a very valid option. It is certainly far simpler than abortion . . . The means of delivering it are far simpler in that one does not need elaborate hospital or clinic facilities, not that one really does for abortion but one certainly needs a certain amount of medical back-up to provide abortion; and, of course, psychologically it is far simpler.

When asked whether women would be likely to have the procedure though not pregnant, he replied:

If one were to indiscriminately use a technique on women who were overdue, then certainly a lot of unnecessary procedures would be done. It is already possible to determine fairly accurately who is and who is not pregnant . . . for instance, 3 days overdue 30 per cent of women are pregnant, at 7 days 75 per cent and 14 days 95 per cent. By taking a basic history from the individual one can arrive at a fairly accurate estimate as to whether she has conceived or not . . . [Menstrual regulation] has been advocated for use between 3 and 14 days, the object being to assure a woman that she remains or returns to being non-pregnant. One does this without a long delay which is a cause of anxiety.¹³⁴

It is possible to determine after the procedure whether or not there had been a pregnancy. He considered that there was a demand for this procedure to avoid the anxiety of unwanted pregnancy as early as possible.

303. Others were less enthusiastic about the method. Professor Rodney Shearman, of the University of Sydney, said:

I am not very happy about this for two reasons. Firstly, in most of the studies that have been published 30 per cent of the women who had the procedure were not pregnant, so they have had an unnecessary procedure. Secondly, even in fairly well trained hands, in that very early stage if the woman is pregnant the pregnancy is often not terminated because it does not occupy much of the uterine cavity and it is missed and they have had to have a second procedure. So—the substantial number of women having unnecessary procedures and the smaller, but still significant, number of women who are having two procedures instead of one. I think menstrual extraction is an unfortunate term. It is a euphemism for abortion in 70 per cent of the cases and I believe the word should not be used. This is a personal view, that it blurs the issues.¹³⁵

133. See Annexe IV.M for description.

134. Evidence, pp. 3174–6, Dr Geoffrey Davies.

135. Evidence, p. 3098, Prof. Rodney Shearman; see also *Medical Journal of Australia*, 22 January 1977, p. 82.

Dr C. K. Churches thought that the procedure should be safe but that it had no advantages except as a 'sop to the conscience'.¹³⁶

304. The Lane Committee considered this subject and pointed out the possible disadvantages which flow from a procedure which may be in fact unnecessary, particularly when it is repeated or used as an alternative to proper contraception. These include the possibility of infection or perforation. The Lane Committee recommended that the procedure be performed by a registered medical practitioner and that it be included in the statistics of abortion.¹³⁷

305. Surveys have shown that certain risks are less in the case of menstrual regulation than in later abortion.¹³⁸ The most serious complication is failure to terminate the pregnancy. Continuing pregnancies have been observed in from 1 to 5 per cent of cases.¹³⁹ For this reason some consider it advisable to wait until the pregnancy has advanced to about 8 weeks. The study referred to suggests that, while the method is safe, only use on a much greater scale will allow the risks to be measured accurately.

306. It seems to us that where an unwanted pregnancy is a probability for a woman there can be advantages in terminating it as soon as possible, provided the operation is performed competently and effectively. In many cases it is preferable to wait a few weeks to ensure the termination is effective. This has to be balanced against the distress and the anxiety of waiting. We do not think the operation of menstrual regulation or early abortion should be subject to special legal restrictions when carried out by a medical practitioner. It would be wrong, however, to regard the procedure as a simple and safe alternative to contraception. Any procedure has its risks, particularly if it is unnecessary. The medical profession should be aware of the risks and alert to the need to avoid unnecessary procedures. The effects of the procedure should be carefully monitored.

307. Further developments in the early diagnosis of pregnancy would eliminate the need for any procedure before pregnancy is confirmed.

Expansion of services

308. From our study of abortion services in Australia we conclude that there are a number of deficiencies which need rectifying. The private clinics appear to provide a reasonable service (not always of the same standard) but they suffer from the disadvantage that they are centrally located. Many women have to travel considerable distances to reach them. The use of older, less safe methods, the lack of experienced medical practitioners and counsellors, the uncertainty of medical attitudes, delays and requirement for hospitalisation are all drawbacks to the hospital service. They have to be set against their advantage in being potentially able to offer a full range of emergency services and up-to-date equipment enabling them to undertake abortions at all stages of pregnancy. There are also the advantages of being in a number of locations and having a full range of obstetric and gynaecological services to offer.

309. The problems faced by hospitals in responding to the demand for abortion services are well illustrated by the South Australian experience. When the new abortion law came into force in 1970 the requirement was laid down that abortions must be performed in hospitals. This led to pressure on hospital resources and hampered, in some ways, the development of expertise which comes with specialisation. Counselling services cannot so easily be organised as in a clinic setting.

136. Evidence, p. 2875, Dr C. K. Churches.

137. Lane report, vol. I, paras. 86-93.

138. *Menstrual regulation* (IPPF, 1976), p. 30.

139. *ibid.*

310. The Mallen Committee has commented on these matters on several occasions and has made a number of recommendations to improve the quality of services. They recommended that finance be available to set up special clinics at all teaching hospitals to carry out abortions, without detriment to other hospital services and teaching needs in obstetrics and gynaecology; that a day clinic be established at one of the teaching hospitals as a pilot study; that minimum standards be determined for prescribed hospitals; and that increased provision be made for social welfare work.¹⁴⁰

311. We heard evidence about South Australian abortion services. A Family Advisory Clinic was established at Queen Elizabeth Hospital. Professor L. W. Cox, of the Queen Elizabeth Hospital, told us that there were no delays at that hospital because of a limited appointment system. In his view there was enough slack in the services for everyone to be seen. He saw some merit in setting up a free-standing clinic provided it was associated with a major institution in case of complications.¹⁴¹

312. Dr Peter Hoopman's view was that very few social workers had been appointed for counselling. He considered that both the Queen Elizabeth Hospital and the Queen Victoria Hospital had to limit other services because of the increasing number of applications for termination. In his view gynaecology patients should be separate from the obstetric ante-natal clinic; he would like to see a department of social gynaecology with pregnancy counselling, psychosexual counselling and a day termination service.¹⁴²

313. The Visiting Medical Specialists Society of the Queen Victoria Hospital stated that no extra beds, facilities or staff had been provided, though provision was made for one full-time social worker. The extra workload was said to interfere with clinical teaching and lead to the overloading of the gynaecology section with referrals for termination. There were also said to be delays of 3 weeks in pregnancy counselling leading to more risks and complications.

314. They put forward detailed proposals for a Family Advisory Clinic to be set up separate from the hospital gynaecology service, as an outpatient facility employing social workers and administrative staff, and with doctors employed on a sessional basis to assess referrals for termination. Patients accepted for termination would have their operation on a day patient basis in the hospital. Other patients, and those requiring tubal ligation, would be referred to the gynaecology clinics as inpatients. An anaesthetist would be employed on a sessional basis for the day patients and all patients would be instructed in family planning and referred to the family planning clinic.¹⁴³

315. These submissions highlight the issues which need to be considered in planning for the expansion of abortion services. Should abortion services be considered as part of general health services, or should they be seen as specialised and separate services? This issue arises partly because of the present inability of hospitals to provide services in this area. A great deal has been left to the responsibility of private clinics and private practitioners. In some cases they have done the job well. Private clinics have provided a service, particularly in regard to counselling, which few hospitals can match.

316. The problems of pressure on resources and attitudes of staff may hamper hospitals in developing their own services. We consider, however, that efforts should

140. Annual Report of the Committee Appointed to Examine and Report on Abortions Notified in SA 1974 and 1975 (hereinafter referred to as the Mallen Committee report); see also Report of the Committee of Inquiry into Health Services in South Australia, 1973.

141. Evidence, pp. 1401-3, Prof. L. W. Cox.

142. Evidence, pp. 1314 ff, Dr Peter Hoopman.

143. Submission 149, Queen Victoria Hospital, Visiting Medical Specialists Society.

be made to overcome these problems and to develop the services now provided by hospitals to an acceptable standard. Abortion services should be seen as part of general health services, accessible to all who need them. This task should not be left exclusively and permanently to private clinics. There is a place for both in the expansion of services.

317. Looking at hospital services, the first question is whether abortion services are to be considered as part of obstetric and gynaecological services, or whether they should be treated as something separate and distinct, i.e. employing separate or sessional staff, or using distinct parts of the hospital or separate premises not used for other purposes. The advantages of separation would be:

- (a) to provide for the special training and skill of medical personnel, and thereby enhance the safety of the operation;
- (b) to ensure that personnel opposed to abortion procedures do not have to participate;
- (c) to protect patients from unfriendly behaviour of staff.

318. On the other hand, there are also many advantages in maintaining an integrated gynaecological service, including expanded facilities for abortion, and in providing abortion services as part of normal hospital services. There is a certain amount of medical hostility to abortion, and some stigma still attaches to the procedure. Emphasising abortion services as something separate would make this more difficult to overcome, with the result that some gynaecologists would remain unfamiliar with abortion techniques and hostile to the operation.

319. We consider that the expansion of hospital abortion services should take place within the framework of existing gynaecological services.¹⁴⁴ We believe this policy would lead to the upgrading of abortion services and to their integration with College training programs. If the policy were widely adopted the pressure on any one hospital or clinic would tend to diminish. We would still see a degree of specialisation as desirable within a broader service, particularly in the larger obstetric and gynaecological hospitals. These specialist hospitals have an obligation to train staff in the full range of fertility control techniques, including abortion.

320. The objective we have in mind should be achieved in a number of ways, depending on the size and scope of the particular hospital. The training and selection of staff, and the provision of day patient facilities and of counselling services, would need to be part of the plan.

321. The selection of staff will present difficulties where there is objection to abortion. There is no question of requiring any doctor to take part in the procedure. Many are involved who may prefer not to be. The Lane Committee observed that they were:

. . . much impressed by the many gynaecologists and nurses who quietly continue to do work which is repugnant to them because they consider this a part of their duty to the patient and to their medical colleagues.¹⁴⁵

There are of course other parts of medical practice which are repugnant to some doctors, e.g. amputation, head injury, gross abnormality or terminal cancer. Nevertheless, the profession as a whole should provide the service.

322. If abortion is part of a hospital service, the attitude of a candidate for appointment may be relevant. The Lane Committee considered the problem of senior

144. Evidence, p. 2869, Dr C. K. Churches.

145. Lane report, vol. I, para. 419.

appointments in areas where an abortion service was needed. Though sympathetic to conscientious objectors, their view was that:

... the number and attitude of consultant obstetricians and gynaecologists is important in determining the level of service which can be provided and, in our view, it is inevitable that the health authorities should prefer for appointment to certain posts those who see abortion as properly part of clinical gynaecological practice.¹⁴⁶

This is a problem which will also need to be confronted and resolved in Australia.

323. The immediate problem is to ensure adequate facilities, proper training, supportive attitudes and skilled counselling. Smaller hospitals could provide for abortion as part of their gynaecology service, and large specialist hospitals could establish special units as part of the hospital service, following the service model of private clinics, such as Preterm. Day clinics would reduce the strain on hospital resources.¹⁴⁷ It is important to ensure that practitioners develop expertise by continuity of experience. It should be part of hospital policy to ensure that abortion services are staffed by specially trained personnel, willing to be involved, and that counselling services are available. In some cases this will be more easily done by establishing a special clinic within the hospital structure.

324. These problems are not unique to Australia, but have been encountered in the United States and in the United Kingdom where there has been an increase in demand for public hospital abortion services.¹⁴⁸ An article reporting on an English hospital concludes that abortion can be performed efficiently in a National Health Service hospital without seriously interfering with the routine gynaecological service. This was by rearrangement of clinic and theatre roles, and by employing lay counsellors.

325. In our view the Departments of Health should develop guidelines for the delivery of abortion services by hospitals and should encourage their adoption.

326. Private clinics will undoubtedly continue to operate so long as public health services do not respond to the demand. The standard of service offered by Preterm, for example, is one which other private and public services could emulate. The variety of services offered by Preterm and other clinics points the way for the expansion of services which should aim at the combination of all kinds of fertility control services including contraception, sub-fertility, abortion, sexual counselling and VD control.

Access to services

327. At present abortion services are not only divided between the public and private sector. They are also unevenly distributed. The main clinic services are concentrated in the cities and the services provided by country hospitals have some unsatisfactory features. In our view country hospitals have an obligation to provide adequate abortion services by organising staff training and providing facilities, counselling and contraceptive services. We consider that guidelines should be established for these services and areas of need identified, particularly among remote and rural communities.

328. Where there is an established need, hospital or clinic facilities could be encouraged to establish appropriate abortion services.

146. *ibid.*, para 425.

147. Submission 747, Dr C. K. Churches.

148. See Tietze, 'Abortion needs and services in the US 1974-75', *Family Planning Perspectives* 8, 2 (1976), p. 58; Hull et al., 'The organisation and results of a pregnancy termination service in a national health service hospital', *Journal of O & G of the British Commonwealth* 81, 8 (1974), p. 577.

329. The absence of proper facilities leaves many women vulnerable, with no alternative but to use unsatisfactory services or to travel considerable distances.

330. Another aspect of access to services is the need for interpreters or counsellors able to deal with members of migrant communities. The guidelines for services should take account of this need in areas where migrants live.

Regulation of private services

331. One submission considered that there should be laws or regulations governing the provision of abortion services, and that it should not be treated as just another medical procedure because of the poor service, excessive fees and punitive approach of the past, and because of the vulnerability of women to exploitation.¹⁴⁹ In addition to the matters already referred to in this report¹⁵⁰ the submission argued that regulations similar to those which had been in operation in New York should apply. These regulations, which were quoted in the submission, required that abortions be performed by doctors in a place where there is qualified supervision in obstetrics and surgery, and where equipment, staff and facilities are provided to handle haemorrhage, shock, cardiac arrest and other emergencies, as well as to apply aseptic procedures.¹⁵¹ Women whose pregnancy is longer than 12 weeks would be dealt with as inpatients.

332. The private free-standing clinics have been set up to fulfil a need not met by public hospitals or private practitioners. This is not so much due to long-standing neglect, but rather to a failure to respond to changes in law and social attitudes, and to the demand for abortion services of good standard. The hostility of some doctors has also been a factor.

333. We have considered whether it is necessary to impose controls over the activities of private clinics, and in particular have considered the regulations mentioned in the submission. They seem to us to be unduly restrictive in application, and might add unnecessarily to the cost of maintaining an efficient service. So far as they apply to first trimester abortions, they no longer are enforced in the United States as a result of a Supreme Court ruling. We note that the Lane Committee recommended that there be no statutory restrictions on the qualifications of practitioners undertaking abortion, no control of fees and no statutory conditions for approval of facilities (non-statutory system was to continue). Our view is that regulations can restrict access without improving the conditions of facilities. They are difficult to administer and can quickly become out of date. Where general anaesthetics are used, conditions laid down by State law have to be complied with. These conditions are of general application.

334. We are not convinced of the need for special legal regulation of abortion services. In our view the best way of ousting undesirable practices is to provide facilities of a good standard sufficient to meet reasonable demands. This should be seen as a responsibility of health and medical authorities, a responsibility which can be fulfilled by expanding the public facilities, along the lines of the clinic model, and by supporting financially and otherwise those parts of the private service which are able to meet adequate standards.

335. Because abortion has been subject to abuse in the past, and because of the vulnerability of patients, we consider that Commonwealth and State health authorities

149. Submission 73, Jo Wainer, Fertility Control Clinic.

150. e.g. counselling by a person other than the doctor; contraceptive counselling services; restriction of abortions to registered medical practitioners; and the protection of doctors and nurses from being compelled to perform abortion.

151. Refers to the New York City Health Code, article 42, abortion services, adopted on 17 September 1970.

should establish guidelines for the delivery of abortion services by public and private abortion clinics, and should encourage their application on a voluntary basis. Resources for the training and employment of medical and counselling staff and for the expansion of facilities could be provided where those standards are met. The matters which may be important in setting standards are:

- medical procedures and equipment
- counselling
- access to hospital emergency services
- provision of necessary pathology tests
- follow-up services, including contraceptive services
- prescribing practices

336. We believe that this approach is to be preferred without resort to legal regulation. More open discussion should lead to public and medical scrutiny. The general practitioner and his patients should be made aware of the facilities available and their nature. They should be able to exercise choice and influence standards.

Incidence of abortion

337. Our terms of reference require us to inquire into and report on the incidence of terminations of pregnancy and we present in this section findings about the world incidence of abortion, about the incidence of abortion in Australia and about the demographic and other characteristics of women having abortions.

World incidence of induced abortion

338. Induced abortion, both legal and illegal, remains the world's most common method of fertility control. It is difficult to obtain sound figures on the incidence of induced abortion owing to the unreliability of reporting systems. Illegal abortions do not appear on official records unless as part of hospital admissions. Legal abortion may be under-reported for reasons of confidentiality, forgetfulness, worry about conforming precisely to the law or tax evasion.

339. The total number of induced abortions, legal and illegal, has been estimated to be between thirty and fifty-five million annually throughout the world.¹⁵²

340. In figure IV.1 we give the rate of reported legal abortions in various countries. Information provided below suggests that the Australian rate is 21.7 for 1976.

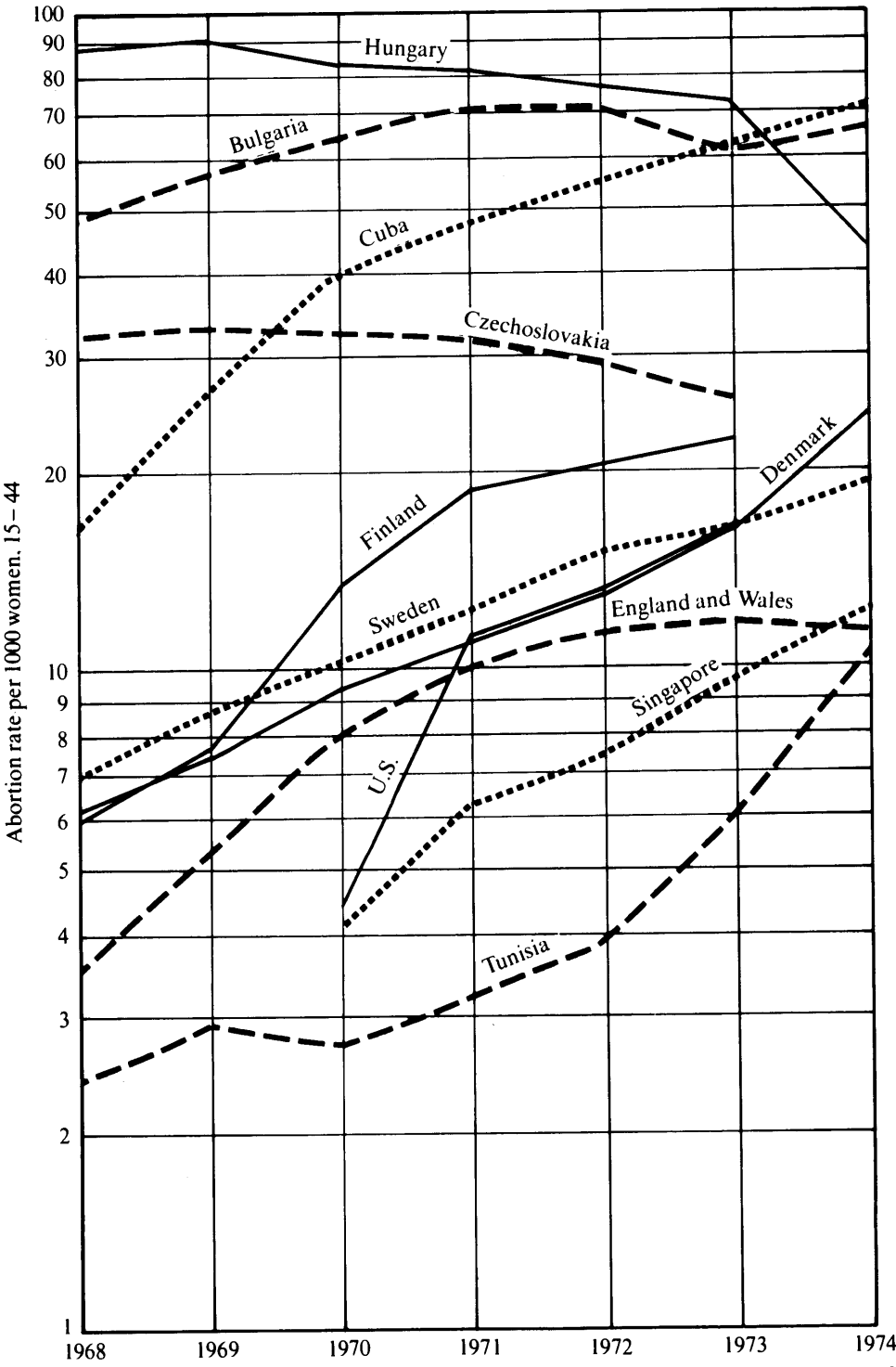
341. Table IV.32 gives the actual numbers of reported legal abortions derived from official records or through government information channels.

342. Table IV.33 provides estimates of illegal abortions in selected countries. The authors who compiled these sets of figures stress that they do not reflect their own evaluation of the incidence, but are cited to illustrate the wide range and low reliability of existing estimates of illegal abortions.¹⁵³

152. A. Klinger, 'Demographic aspects of abortion', *International Population Conference*, London, 1969, vol. 2 (International Union for the Scientific Study of Population, London), pp. 1153-64; International Planned Parenthood Federation, *Survey of world needs in family planning* (IPPF, London, 1974).

153. Christopher Tietze & Marjorie Cooper Murstein, 'Induced abortion: 1975 factbook' *Reports on Population—Family planning*, no. 14 (2nd edn), December 1975, p. 13.

Figure IV.1 Legal abortions per 1000 women aged 15-44; selected countries, 1968-74 (Semilog scale)



Source: C. Tietze & M. Cooper Murstein, 'Induced abortion: 1975 factbook', *Reports on Population and Family Planning*, no. 14 (2nd edn), December 1975, p. 14.

Table IV.32 Number of legal abortions annually (selected countries)

| Country | Number | Year |
|----------------------------------|-------------|------|
| Canada | 48 700 | 1973 |
| Czechoslovakia | 81 200 | 1973 |
| Denmark | 24 900 | 1974 |
| England and Wales ^(a) | 130 000 | 1976 |
| Finland | 23 400 | 1973 |
| Hungary | 102 600 | 1974 |
| Japan | 2-3 million | 1970 |
| Korea | 390 000 | 1973 |
| Netherlands | 38 500 | 1972 |
| Romania | 51 700 | 1967 |
| Scotland | 7 500 | 1973 |
| Singapore | 6 600 | 1974 |
| Sweden | 30 600 | 1974 |
| Tunisia | 12 400 | 1974 |
| USA ^(b) | 9 000 000 | 1974 |
| | 1 million | 1975 |
| USSR | 10 million | 1970 |

Source: Except as indicated these figures are from C. Tietze & M. Murstein 'Induced abortion: 1975 factbook', *Reports on Population and Family Planning*, no. 14 (2nd edn), 1975.

(a) official figures for Jan.-Nov. inclusive and unofficial estimate for December (quoted in *Daily Telegraph*, 7 January 1977).

(b) Weinstock, Tietze et al. 'Abortion needs and services in the US, 1974-75', *Family Planning Perspectives* 8, 2 (1976).

Table IV.33 Estimated number of illegal abortions, abortion rates and abortion ratios: selected countries, around 1965-70

| Country | Number (in thousands) | Rate per 1000 women, 15-44 | Ratio per 1000 live births |
|----------------------------|--------------------------|-------------------------------|-------------------------------|
| Australia | 40-80 | 16-33 | 150-310 |
| Austria | 70-300 | 50-210 | 620-2670 |
| Belgium | 30-400 | 16-210 | 210-2820 |
| Canada | 20-120 | 5-28 | 50-320 |
| Chile | 100-200 | 47-94 | 420-840 |
| France | 250-1000 | 24-120 | 300-1410 |
| German Democratic Republic | 60-150 | 18-44 | 250-630 |
| German Federal Republic | 50-3000 | 4-250 | 60-3790 |
| Greece | 60-100 | 29-48 | 410-690 |
| India | 2000-6000 | 16-48 | 100-300 |
| Italy | 500-2000 | 43-170 | 560-2220 |

Source: Tietze & Murstein, 1975, pp. 26-7.

Incidence of abortion in Australia

343. There is no statutory requirement to report induced abortions in any State in Australia except South Australia where abortion is a notifiable procedure that must be performed in a hospital. There are some statistics available from the Northern Territory. Information about the number of induced abortions taking place is sometimes concealed by women and doctors. Estimates of the number of operations performed in Australia each year, therefore, contain an element of uncertainty.

344. Official statistics from the Committee Appointed to Examine and Report on Abortions Notified in South Australia state that 2916 abortions were performed in South Australian hospitals in 1975.¹⁵⁴ If the South Australian pattern were repeated nationally then, comparing the age distribution of the female population and the age of mothers at confinement, a national figure of between 30 000 and 37 000 abortions could be estimated.¹⁵⁵ Other data, however, suggest that the rate of notified abortions in South Australia is below the national rate and that the official figure is, in fact, lower than the actual figure. There may be a significant number of abortions performed in South Australia which are not notified and do not appear in official statistics. The Mallen Committee reported that it has good reason to suspect that not all abortions are reported.¹⁵⁶ Dr E. G. Cleary estimated that between 25 and 50 per cent of abortions performed in South Australia are not reported.¹⁵⁷

345. All sources agree however that thousands of induced abortions occur each year in Australia. Our estimate is over 60 000 abortions per year. This estimate is based on the following data: figures supplied by the Department of Health; a Commission survey of forty-four public hospitals throughout Australia; a Commission survey of abortion clinics; information supplied by the Australian Council of the Royal College of Obstetricians and Gynaecologists and by referral agencies; and information supplied by private doctors who perform abortions.

Medibank services

346. The Department of Health supplied the Commission with statistics (see table IV.34) derived from a recently developed departmental statistical model of all services rendered under Medibank for March 1976 expanded to an estimated 75 million services on a full year basis for 1976–77.¹⁵⁸ These statistics relate to persons who claimed medical benefits from Medibank and do not include services rendered to standard ward patients in public hospitals or to persons who did not claim or who claimed through private health funds. These figures are considered to be a reasonable guide of experience under the fee-for-service insurance system only.

Explanation of table IV.34

347. Items 6460G and 6464S. 'Uterus, curettage of, with or without dilatation.' This operation can be performed for many medical reasons. However, if a woman were pregnant a miscarriage would be induced. It is probable that a significant proportion of these 109 000 dilatation and curettage operations were elective abortions.

348. Item 6469. 'Evacuation of the contents of the gravid [i.e. pregnant] uterus by curettage or suction curettage.' This item relates to aborting a partially developed foetus and can be performed for any number of reasons, including, for example, where excessive bleeding indicates that a natural miscarriage is about to occur; where the foetus has already died from natural causes but has not been expelled by the uterus; when the mother has contracted rubella in the early stages of pregnancy; or for psychiatric or non-medical reasons.

349. Item 6508. A hysterotomy is performed only to procure an abortion.

154. Mallen Committee report for 1975.

155. Ruzicka, 'Demographic aspects of abortion' at Annexe IV.O.

156. Mallen Committee report for 1975, p.5.

157. Evidence, pp. 1236–7, Dr E. G. Cleary.

158. Commission correspondence, confidential file S266.

Table IV.34 Medical benefits schedule statistics (based on an estimated 75 000 000 services on a full year basis, 1976–77)

| Item no. | NSW + ACT | Vic. | Qld | SA + NT | WA | Tas. | Aust. |
|---|--------------|--------|-------|------------|-------|-------|---------|
| 'Uterus, curettage of, with or without dilatation' | | | | | | | |
| 6460G | 9 685 | 10 613 | 2 473 | 3 879 | 4 590 | 505 | 31 745 |
| 6464S | 36 646 | 19 355 | 5 709 | 6 064 | 6 829 | 2 704 | 77 307 |
| Total | | | | | | | 109 052 |
| 'Evacuation of the contents of the gravid uterus by curettage or suction curettage, not covered by item 6460 or 6464' | | | | | | | |
| 6469 | 27 345 | 15 270 | 834 | 2 145 | 3 237 | 314 | 49 145 |
| 'Hysterotomy' | | | | | | | |
| 6508 | 192 | 355 | 55 | 27 | 150 | 14 | 793 |

Note:

'G' items refer to services where the patient was not referred by another medical practitioner.

'S' items refer to services where the patient was referred to a recognised specialist by another medical practitioner.

Source: Department of Health.

350. Taking a conservative estimate that 10 per cent of dilatation and curettage operations result in abortions, the Department of Health data yield the following estimate of the number of abortions performed in 1976.

| | |
|--|--------|
| (Items 6460G and 6464S)—Curettage and dilatation | 10 905 |
| (Item 6469)—Evacuation of gravid uterus | 49 145 |
| (Item 6508)—Hysterotomy | 793 |
| Total | 60 843 |

This figure does not take into account public ward hospital patients or those who claimed benefits from private health funds and it is therefore an underestimate.

351. Applying the same formula to the South Australian–Northern Territory figures from Medibank, 10 per cent of dilatation and curettages (994) plus items 6469 (2145) and 6508 (27) make a total of 3166 abortions. The number of notified abortions performed in South Australia in 1975 was 2916 and in the Northern Territory 177, making a total of 3093. The Medibank figures do not include public ward hospital patients and private fund patients and it is not known how many South Australian abortions would come into those categories.

Hospitals and clinics

352. Our own investigations of hospitals and clinics produced figures of nearly 30 000 abortions known to have occurred and estimates of up to 58 000 abortions.

353. We conducted a survey of larger public hospitals requesting information on admission procedures for patients requesting a termination of pregnancy.¹⁵⁹ Question 5 of the survey asked the hospital for the number of abortions performed between January and December 1975. Results are summarised in table IV.35.

159. Commission research report, no. 3, 1976.

Table IV.35 Hospital admissions survey

| State | Number of hospitals | Number of abortions performed during 1975 |
|------------------------------|---------------------|---|
| New South Wales | 15 | 2748 |
| Victoria | 10 | 1291 |
| South Australia | 7 | 1962 |
| Queensland | 1 | 22 |
| Western Australia | 4 | 533 |
| Tasmania | 4 | 216 |
| Australian Capital Territory | 1 | 102 |
| Northern Territory | 1 | 185 |
| Total | 43 | 7059 |

Some, but not all, of these abortions would have been performed on public patients.

354. We also approached the three abortion clinics that operate in Australia and asked them for the number of abortions performed in 1975.¹⁶⁰ Results are summarised in table IV.36.

Table IV.36 Abortion clinics survey

| Clinic | Abortions performed during 1975 |
|--|---------------------------------|
| Population Services International, Sydney (estimate) | 8 000 |
| Preterm, Sydney (estimate) | 4 000 |
| Fertility Control Clinic, Melbourne | 8 000 |
| Total | 20 000 |

355. The total of tables IV.35 and IV.36 is 27 059. In fact 2916 abortions were notified in South Australia in 1975. Further information made available to us by the Department of Health shows the number of induced and spontaneous abortions in three States as follows:

| | Induced and spontaneous abortions |
|-------------------------|-----------------------------------|
| Queensland, 1974 | 3693 ^(a) |
| Western Australia, 1975 | 3391 ^(b) |
| Tasmania, 1975 | 741 ^(c) |

Source:

- (a) Australian Bureau of Statistics, Queensland Office.
- (b) Australian Bureau of Statistics, Western Australian Office, Bulletin W83/76—'Hospital inpatient statistics'.
- (c) Australian Bureau of Statistics, Hospital morbidity 1975.

160. Commission correspondence, confidential file S209.

Medical practitioners

356. The Commission conducted a nation-wide systematic sample survey of general practitioners in Australia on the subject of their medical training and practice.¹⁶¹ Doctors were asked how many of those patients who had consulted them seeking an abortion in the last 6 months they knew had actually had their pregnancies terminated. Calculations on data derived from this survey give a crude total of 58 400 abortions performed during 1976. (For table see Annexe IV.N.) Other information suggests that about 60 per cent of clinic patients are referred by medical practitioners.

357. The Australian Council of the Royal College of Obstetricians and Gynaecologists supplied some estimates of the numbers of abortions performed privately and in hospitals. They estimated between 30 000 and 60 000 abortions each year.¹⁶²

358. Abortion information services and abortion law reform associations in the States and Territories of the Commonwealth provided additional information on the incidence of abortion. This is speculative but it helps to build up an estimate of the numbers of abortions performed in Australia. Estimates from various sources suggest that at least 10 000 abortions are performed each year by private doctors.

Conclusion

359. Our conclusion is that there are 60 000 or more abortions in Australia each year.

360. The Australian Bureau of Statistics report that there were 233 050 live births in Australia in 1975.¹⁶³ On our estimate of 60 000 abortions, this gives a ratio of abortions to live births of 1:3.9. This finding is consonant with the ratio of estimated abortions to live births in other western industrialised countries which range from 1:4 to 1:6.7.¹⁶⁴ Another mode of comparison is the rate of abortions per 1000 women between 15 and 44. Based on population figures of 2 884 691 women in that age group on 30 June 1975¹⁶⁵ the Australian abortion rate would be 21.7. This rate is the same as that in the United States in 1975.¹⁶⁶ The rate for women resident in England and Wales in 1971 was 10.¹⁶⁷

Characteristics of women having abortions

361. We set out to establish the characteristics of women in Australia who have abortions. This presented a number of problems. The only State with official statistics is South Australia. Only the age, marital status and reason for abortion are published. Our survey of abortion morbidity rates in hospitals and clinics produced demographic data about the women concerned. More data are available from surveys of women having abortions at private clinics in Sydney and Melbourne, but of course these are not necessarily representative of all women having abortions. The research material is diverse in the samples used, the type of data collected and the period during which the survey was conducted. It ranges from a small survey of 349 women done in one public hospital in Adelaide in 1971 to a large-scale survey of an unspecified number of women counselled over a period of 2 years by an abortion referral agency in Brisbane.

161. Commission research report, no. 1, 1976 at Annexe III. A.

162. Submission 1246, Royal College of Obstetricians and Gynaecologists, Australian Council.

163. ABS, oral advice to Commission, 1 November 1976.

164. Weinstock, Tietze et al., 'Abortion needs and services in the United States 1974-75', *Family Planning Perspectives* 8, 2 (1976), pp. 58-59.

165. Figures supplied by Australian Bureau of Statistics.

166. Weinstock, Tietze et al., pp. 58-9.

167. Lane report, vol. II, p. 32; the number of abortions was 126 777 compared with approximately 102 000 in 1976.

362. We have brought together data from a number of separate sources for the purpose of drawing general conclusions about women seeking abortions. These sources are:

- A. the annual reports of the Committee appointed to Examine and Report on Abortions Notified in South Australia;
- B. a study of 1007 women having a termination of pregnancy at Preterm in 1974¹⁶⁸;
- C. a study of two groups of 1736 and 359 women having abortions at the Fertility Control Clinic, Melbourne, in 1973–74⁶⁹;
- D. a study of women seeking termination of pregnancy through Children by Choice in Brisbane¹⁷⁰;
- E. information about women having abortions at King Edward Memorial Hospital, Perth¹⁷¹;
- F. a sample of 2788 abortion cases in three public hospitals, three clinics and two private hospitals in three major centres in Australia in 1976; (tables based on these data are at Annexe IV.Q);
- G. Dr Lado Ruzicka's detailed analysis of the demographic data about South Australian women having abortions (Annexe IV.O).

These statistics and data demonstrate a number of constant factors and enable a picture to be built up of women seeking abortions. Unless otherwise stated the overall pattern shown by each survey is similar.

Age (all studies)

363. About 30 per cent of all abortions occur to women under the age of 20 (range 29–33 per cent) whereas this group accounts for only 10–11 per cent of live births. In South Australia the age-specific abortion rate (i.e. number of abortions per 1000 women of that age) is highest for women in the 16–19-year-old group, followed by the 20–24-year-old group and the 25–29-year-olds. If our estimate of 60 000 abortions is correct it would seem that women under 20 account for 18 000 abortions each year compared with 26 000 live births and that about 40 per cent of pregnancies in this age group end in abortion.

364. Ruzicka's analysis shows that women under 20 are more likely to have their pregnancies terminated than women in the age range 20–34. After 34 the ratio of abortion to pregnancy rises sharply.

Marital status (all studies)

365. The surveys all show that about half the women having abortions are single (range 49–55 per cent). About one-third are married (range 31–40 per cent) and the remaining number are divorced, separated or widowed. Australian statistics show that ex-nuptial births account for about 9–10 per cent of total live births.¹⁷² The number of ex-nuptial births in 1974 was 23 000; if our estimate is correct there are more than 30 000 abortions arising from ex-nuptial conception (more if divorced women and others are included in ex-nuptial figures). Abortions would account for about 56 per cent of ex-nuptial pregnancies; Ruzicka's figure for South Australia is 47.8 per cent in 1974. The figures for married women would be 20 000 abortions and 222 000 births, abortions being about 8 per cent of total pregnancies; Ruzicka's figure for South Australia in 1974 is 6 per cent.

168. Snyder & Wall, 1967.

169. Submission 73, Jo Wainer.

170. Rigg, Commission research report, no. 4.

171. Submission 1246, RCOG, Australian Council.

172. Australian Bureau of Statistics.

Number of children—previous pregnancies (B, D, F & G)

366. Here the figures show quite a wide range. Between 40 and 50 per cent (range 44–51 per cent) of the women having abortions have not had any children. From 77 to 90 per cent of the unmarried women had never been pregnant before whereas less than 10 per cent of the married women had never been pregnant. In the Preterm study 77 per cent of the never married women had no child and 16 per cent had one child; whereas 91 per cent of the married, separated, divorced and widowed women had one child and 72 per cent had two or more children.

367. Ruzicka's study of South Australian figures shows that 11.5 per cent of pregnancies occurring to women with no children were terminated; 9.8 per cent of those to women with two children, then rising steeply with each additional child. However, only 2.4 per cent of pregnancies occurring to women with one child were terminated. The study shows that the highest rate of abortion per 1000 conceptions is among women under 20 with no children, women over 35 with two children and for women of all ages with three or more children (the rate increases with age, sharply over 35).

Country of birth

368. Figures on ethnic origin were available only from studies B, C and D. The percentage of Australian-born women ranged from 63 to 81 per cent. The next largest group was from the UK (7–9 per cent).

369. Immigrants from Yugoslavia, South America, Greece, Italy and Turkey represented 16 per cent of the Preterm sample (166). In all these ethnic groups there was a much lower percentage of women under 22 than in the case of Australian-born (range 7–27 per cent as against 42 per cent Australian) and correspondingly more women over 22, and especially over 30. There were also fewer never marrieds (7 per cent compared with 65 per cent Australian). The numbers involved are in some cases quite small.

Religion

370. Three studies (B, C and D) reported on religion. They showed between 44 and 61 per cent Protestant (or non-Catholic Christian); 24–30 per cent Catholic; 10–14 per cent no religion or agnostic; 1–6 per cent Orthodox; the proportion of Catholics is similar to that in the general population in all studies, but there are more women claiming to be agnostic or to have no religion (10–14 per cent) compared with the population as a whole (5–10 per cent).

Employment (B, C & D)

371. About half the women in the Children by Choice survey had some paid employment. Three-quarters of the single and 45 per cent of the married women in the Melbourne sample were in the workforce. Unemployed women and housewives represented only 19.6 per cent of the Preterm survey. A further 11.9 per cent were students.

Northern Territory

372. Dr Ruzicka's study also looks at abortion statistics from the Northern Territory where 183 and 177 abortions were performed in 1974 and 1975 respectively. These show a much lower rate of abortions for Aborigines than for others. The age-specific abortion rates for non-Aborigines were similar to those for South Australia. It is noted that 13 and 16 per cent of women who had abortions in 1974 and 1975 respectively were sterilised.

Conclusions

373. Women seeking abortions fall into two main groups:

- young single women with no children mainly aged 15–24
- married women with two or more children

Some of the single women may be in a stable relationship; many, however, would not be in a supportive relationship with the father. The problem is often to provide for contraception outside a stable relationship and to convince young people of the need for and benefits of effective contraception.

374. For the married woman it seems that abortion is resorted to in order to limit the size of the family when the desired number of children is attained. It appears that migrants from southern European countries are more likely to use abortion for this purpose than the Australian-born, possibly because their customary methods of contraception are less effective and their access to modern contraception restricted by linguistic problems.

375. The migrant population, particularly those of southern European origin, seem to have a lower abortion rate among the young and single and a higher rate among the older women. They are however represented in all categories.

Changing patterns of abortion

376. The opponents of liberalised abortion law frequently argue that a relaxation of the law will lead to an increase in the number of abortions and to disregard of family planning services.¹⁷³

377. In South Australia there was a big increase in the number of abortions in the first 3 years, but this increase levelled out in 1974 and there is now only a small increase proportional to the increase in the total population.¹⁷⁴ Amongst those seeking abortions women 19 years old or less have decreased slightly in numbers since 1973 whilst those of 20–29 have increased in number.

378. There are no statistics for other States. It seems probable that there were significant numbers of illegal abortions performed for some years before the law was liberalised in some States. It is also likely that there was an increase in the number of abortions performed in Victoria and New South Wales after the Menhennit and Levine rulings in 1969 and 1972 respectively. It cannot be shown conclusively how great this increase was or whether it has levelled out yet. The Medibank figures may help to show trends in future years.

379. The pattern in the United Kingdom has been similar to that in South Australia. There was an increase in the number of abortions in the first few years after the Abortion Act 1967 came into force. For the last 2 years, however, the number of legal abortions performed on resident women has decreased steadily.¹⁷⁵ This is ascribed to the assumption of responsibility for family planning by the National Health Service.

Resident abortions England and Wales

| | |
|------|--|
| 1974 | 109 432 |
| 1975 | 106 648 |
| 1976 | 102 000 (Jan.–Nov. and estimated Dec.) |

173. e.g. Submissions 131, RTLA, SA; 1146, Dr J. J. Billings.

174. Mallen Committee report for 1975.

175. Office of Population Censuses and Surveys Monitors.

380. In the United States the number of legal abortions has been increasing since 1970 and has not yet levelled out.¹⁷⁶

381. One trend which seems to emerge in Australia is that of an increase in the rate of teenage abortions and ex-nuptial live births. This trend has been pronounced but may now be decreasing. South Australian figures show a levelling out in the number of teenage abortions in 1973 and later years; this is paralleled by a reduction in the rate of ex-nuptial live births to teenagers in Australia as a whole since 1972.¹⁷⁷

382. Another trend in the abortion pattern is that in South Australia, Victoria and New South Wales abortion is now performed openly and legally in hospitals and specialised clinics. Despite the probable increase in abortions there has been a reduction in the mortality rate of legal abortion. Our research also shows that the mortality rate for abortions in the three States mentioned is very low. Studies in other countries show that the legalisation of abortion tends to lead to lower mortality and morbidity, due partly to the skill and experience gained by medical practitioners performing abortions openly in satisfactory conditions.

383. For the future it is our view that to achieve a significant reduction in the number of abortions it is necessary to take effective steps to expand contraceptive services, especially those designed to meet the needs of young single people and other groups with special needs. The level of contraceptive use among married people is high. In the 1970s over 90 per cent of fertile married couples who wished to avoid pregnancy were practising some form of contraception. The conclusion we draw from our investigations as a whole is not that abortion leads to disregard of family planning services, but that the provision of effective education, information and services may lead to more effective contraception by women at risk of unwanted pregnancies.

Consequences of abortion

Introduction

384. The Commission's terms of reference require us to report on:

- (d) the social, economic, psychological and medical pressures on women in determining whether to proceed with unplanned or unwanted pregnancies, having regard to:
 - (iii) . . . the social, psychological and medical results of termination of, or and failure to terminate such pregnancies.

385. We received a great deal of conflicting evidence on the subject of abortion and its effects, both in written submissions and in oral evidence. Dr Hilgers, Assistant Professor of the Department of Gynaecology and Obstetrics, St Louis University, School of Medicine, gave lengthy evidence to the Commission in which he stressed the medical hazards of legally induced abortion.¹⁷⁸ He quoted statistics on abortion-related maternal mortality and morbidity, complications in later pregnancies and psychological complications. He referred to a 1970 report by the RCOG which called for a study of the long-term hazards of abortion.¹⁷⁹ A WHO report on long-term consequences is due for publication in 1977.

176. Weinstock, Tietze et al., 'Legal abortions in the United States since the 1973 Supreme Court decisions', *Family Planning Perspectives* 7, 1 (1975).

177. L. T. Ruzicka, 'Fertility decline in Australia—emerging new strategy of family formation?', in *Towards an understanding of contemporary demographic change*, Australian Family Formation Project, Monograph no. 4, pp. 13–15.

178. Evidence, pp. 182–323, Dr. T. W. Hilgers.

179. 'The Abortion Act 1967: findings of an inquiry into the first year's working of the Act', *Br. Med. J.* 2, (1970), pp. 529–39.

386. Dr Hilgers referred to:

... a report of a World Health Organisation scientific group which stated that 'abortion may impair a woman's health through a variety of complications. These may occur at the time of or soon after abortion, or be discovered much later, perhaps in connection with another pregnancy or with efforts to become pregnant again. The complications may result in the death of a woman'.¹⁸⁰

In his view the non-fatal complications which result from the abortion procedure present a significant public health problem.

387. Other submissions drew our attention to the possible harmful effects of abortion on the physical and mental health of the woman.¹⁸¹ Dr E. G. Cleary stressed that younger women are at greater risk of complications, especially when abortion occurs in a first conception. He referred to a study reporting that the complications predispose the women concerned to pelvic inflammation, infection, infertility and spontaneous abortion—effects which may not become obvious for some years.¹⁸²

388. Others were of the view that harmful effects could be minimised if abortions were performed earlier.¹⁸³ It was suggested to us that the dangers of abortion were exaggerated and that the South Australian studies, conducted soon after the law was changed, showed morbidity rates higher than those which might prevail when abortions are performed by experienced practitioners using appropriate techniques.¹⁸⁴

389. It is important to establish exactly what risks are involved for women who contemplate abortions and what factors increase or decrease those risks. Information about these risks is needed to enable the woman and her doctor to make a proper assessment of the situation.

390. In view of the conflicting opinions held by medical experts and the numerous reports published, we decided to have prepared for us an objective evaluation of the consequences of abortion. To carry out this aim a special research project was set up to conduct a detailed examination of overseas and Australian literature on the consequences of termination of pregnancy, and to conduct a survey of complication rates of abortion in a sample of Australian hospitals and clinics. The project was guided by a Steering Committee composed of:

Professor L. Cox
Department of Obstetrics and Gynaecology
University of Adelaide

Professor H. Lancaster
Department of Mathematic Studies
University of Sydney

Dr L.T. Ruzicka
Department of Demography
Australian National University

180. Reference is to *Spontaneous and induced abortion*, report of a WHO scientific group, WHO Technical Report series, Report no. 461 (1970), p. 37.

181. e.g. Submissions 160, Pregnancy Support Service, ACT; 197, ACT RTLA; 522, RTLA (Tas. Division); 585, NSW RTLA; 747, Dr C. K. Churches; Evidence, p. 1734A, Dr K. G. Cockburn.

182. Evidence, p. 1238, Dr E. G. Cleary.

183. e.g. Evidence, p. 811, Prof. J. Leeton; p. 1402, Prof. L. W. Cox.

184. J. M. Miller, 'Medical abortion in South Australia: a critical assessment of early complication', *Med. J. Aust.*, 28 April 1973, pp. 825–30; 'Therapeutic termination of pregnancy in private practice', *Med. J. Aust.*, 18 April 1973, pp. 831–4.

Professor B. Raphael
Department of Psychiatry
University of Sydney

Dr B. Wren
Honorary Consultant in Obstetrics and Gynaecology
Royal Hospital for Women
Sydney

391. The report of the Steering Committee, entitled 'The sequelae of abortion', together with a glossary of terms, is at Annexe IV.P. The main conclusions of the research report are summarised in this section; our conclusions are based on the material in it. Details of our survey of public and private hospitals and clinics are set out at Annexe IV.Q together with tables. The survey has not been written up in full.

The consequences: definition

392. The consequences (or 'sequelae' as these are referred to in the research report) of abortion are the effects of an induced abortion, either in association with the operation or following on from it. They can be either physical or psychological in nature. Social and demographic factors are also included as consequences of abortion in a number of studies.

393. The consequences of abortion are classified as early or late. Early complications occur at the time of the procedure or may follow in a few hours, or a few days. Late consequences are long-term or latent effects, both physiological and psychological, or, in the wider sense, social and demographic. In general, the kinds of complications vary according to the stage of pregnancy at which the abortion is performed.

Mortality of abortion

394. The abortion deaths in Australia in recent years are 1964-66: forty-five; 1967-69: twenty-five; 1970-72: twenty-five as recorded by the NH & MRC. There has been one death in the period 1973-76 inclusive arising from legal abortion and this was attributable to the administration of anaesthetic.¹⁸⁵

395. High mortality rates generally apply when abortion is illegal. The research report shows that when abortion is legalised the rate of deaths due to abortion (case fatality rates)¹⁸⁶ declines. The main cause is that legal abortions are carried out by qualified and skilled practitioners under less hazardous conditions.¹⁸⁷ It appears that as medical personnel gain experience, and as methods are improved, mortality of legal abortion declines.

396. The imposition of restrictive abortion laws in countries where the law had been liberal has led to a significant increase in the case fatality rates and in the population mortality rates. This has occurred in Romania where the case fatality rates are the highest in Europe.

185. There in South Australia in the year 1976, not directly attributable to abortion procedure:

'I would advise that the Committee determined that this death, recorded as an abortion death as a result of post-operative complications, should be accompanied by a supportive statement indicating that it was considered to be directly attributable to the administering of an anaesthetic, the anaesthetic being maintained following the completion of the abortion procedure in order to undergo a further planned sterilisation operation.'

Commission correspondence, Sir Leonard Mallen, 10 December 1976.

186. Also known as death-to-case rates.

187. A. Keith Mant, Department of Forensic Medicine, Guy's Hospital, London, in 'Methods and dangers of termination of pregnancy', *Proceedings of the Royal Society of Medicine* 62 (1969), p. 829.

397. Overseas material shows that the likelihood of death increases with the length of pregnancy, especially after the eighth week of gestation. Those countries which perform abortions only or primarily in the first trimester by vaginal methods have very low death rates. The *Medical Journal of Australia* noted that the four deaths due to legal abortion which occurred in 1970–72 were all related to pregnancies of between 15 and 20 weeks duration.¹⁸⁸

398. Methods which involve opening the abdomen (hysterotomy/hysterectomy) greatly increase the risk of death, and if sterilisation accompanies an abortion the risk of death is also greater. The lowest risk is from vacuum aspiration and dilatation and curettage methods in early pregnancy.

Conclusions

399. Based on today's available methods, and looking to the future, it seems likely that under the best of conditions—that is, early induced abortion using the safest methods, with an experienced operator—the mortality ratio of legally induced abortion could be expected to remain at one per 100 000 procedures. We have estimated that at least 60 000 abortions occurred in 1976 in Australia; as mentioned, there has been one death since 1973.

400. The abortion death rate is considerably lower than the death rate from other causes in pregnancy and childbirth. In Australia there are approximately twenty maternal deaths per 100 000 live births.

Morbidity of induced abortion

401. The most common early complications of abortion are infection, haemorrhage, perforation of the uterus, cervical tearing and retained products.

402. The assessment of morbidity in association with induced abortion appears to be more difficult than for other surgical procedures: it is a contentious operation; it takes place within a context of changing law, medical practice and technology; the criteria vary and are often ill-defined; differing motivations may be present as sub-conscious factors influencing outcomes.¹⁸⁹ However, despite the complexity of assessment, some generalisations can be made about the factors which have an effect on the complication rates.

Length of pregnancy

403. The later in the pregnancy the abortion is performed, the more likely the patient is to incur complications—the risk is two to three times as high in the second trimester as in the first. Factors contributing to late abortions are social and psychological in the patient; administrative, legal and medical delays on the part of providers.

First trimester methods

404. Vacuum aspiration appears to entail fewer complications than other methods if used in the first trimester. Major complications with this method used by experienced operators are rare.

Second trimester methods

405. A number of studies show that abdominal methods (hysterotomy or hysterectomy) entail significantly higher complications than intra-uterine induction

188. *Med. J. Aust.*, 22 January 1977, p. 83.

189. See Annexe IV.P, paras 110–23.

methods. In the light of the evidence it is our view that abdominal methods should be avoided unless there are significant medical indications for such procedures.

Experience of operator

406. Almost all studies show a significant decline in morbidity with an increase in experience and skill of the operator. It may, in fact, be the most important variable in serious complications associated with each stage of pregnancy. In evidence to the Commission Dr C. K. Churches and Professor Rodney Shearman stressed the importance of specialised experience in abortion.¹⁹⁰

Sterilisation

407. Sterilisation of patients in association with abortion has been found to increase the risks to life and health and to increase the likelihood of adverse psychological consequences.¹⁹¹ Some studies find a correlation between lower socio-economic status and sterilisation, which might increase morbidity, but this too is a changing situation. In the light of this evidence it is our view that sterilisation should not be carried out in association with induced abortion, unless there are strong medical, social or psychological indications for it. Sterilisation should not be made a condition of obtaining an abortion.

Pre-existing medical conditions

408. Where a patient has relevant medical conditions at the time of the abortion procedure, the morbidity rates may be three or four times higher. Such a patient might also be at greater risk in full-term birth.

Legality of abortion

409. The liberalisation of abortion laws has, on the whole, led to a significant reduction in the rate of complication due partly to the competence and skill of the practitioner and partly to a combination of other factors.

Abortion facilities

410. Free-standing clinics performing early abortions find lower morbidity rates in their patients than do hospitals. This is probably due to the greater experience and skill of their operators and to the specialised care offered.

Australian morbidity and the Commission survey

411. The research report sets out the results of several studies of the morbidity rates in South Australian hospitals soon after the liberalisation of the law came into force in 1970.¹⁹² The rate of complication was considered to be higher than might otherwise be the case because of the high incidence of hysterotomies and sterilisations. Later studies in South Australia showed a reduction in the complication rate, due possibly to improvements in skill, adoption of the vacuum aspiration method and reduction in the proportions of hysterotomies and sterilisation procedures.

412. A series of 203 abortions performed in Newcastle had no significant morbidity; these received specialised treatment and assessment.

413. The annual report of the Committee appointed to Examine and Report on Abortions Notified in South Australia includes information about post-operative complications. These can only be taken as a rough guide, as the Committee itself

190 Evidence, pp. 2868–79, Dr C. K. Churches; p. 3095, Prof. R. Shearman.

191 See Annexe IV.P, paras 150–3, 258–9.

192. *ibid*, paras 123 ff.

notes that it feels sure that all complications are not being reported.¹⁹³ Nevertheless the figures show some improvement in the percentage of cases with no complications. In its report for 1975 the Committee accepted with reserve the figure of 91.5 per cent reported uncomplicated, but noted that 3.6 per cent were not stated; the Committee felt that a reported 4.8 per cent of complications:

... even if accurate, is surgically unacceptable in a procedure which is popularly regarded as minor.¹⁹⁴

The Committee mentioned the real difficulties in ensuring accuracy of reporting. The complication may occur after the return visit and the patient may not return to the doctor or may see a different doctor.

414. We sponsored a research project to determine the complication rate at a number of public hospitals, clinics and private hospitals in three major centres (see Annexe IV.Q). The 2 788 cases show a complication rate of less than 1 per cent at the time of the procedure. No cervical tearing was reported. Of the 1 785 cases which were followed up, 3.9 per cent had or were suspected to have retained products and 0.4 per cent had a later blood loss of over 301 ml. Seventy-one (4.3 per cent) were retained in or readmitted to hospital and forty-nine (2.8 per cent) had other complications.

415. Nearly all the procedures (96.3 per cent) were by vacuum aspiration and most (77.7 per cent) had general anaesthetic. Only 2.1 per cent were sterilised at the time of the operation. Further analysis of the survey statistics is expected to reveal what factors had a special influence on the recorded complications.

Long-term physical consequences of induced abortion

416. Inadequate information is available about the long-term effects of abortion and about late complications which may occur. In countries which have had legal abortion for some time, studies have been carried out but these are subject to many uncertainties and variables and are in conflict about the conclusions to be drawn. A long-term prospective study is being conducted in Europe by the World Health Organisation. The findings, which are to be published in 1977, will cope with the many variables and complexities involved in assessing the long-term consequences.

417. On the basis of certain published studies, Dr Hilgers submitted to us that late physical complications present the most significant medical and ultimate sociological consequences of abortion. He mentioned complications in subsequent pregnancies and childbirth such as premature labour, ectopic pregnancy and sterility.¹⁹⁵ Similar conclusions were made in the Wynn report which found that abortion reduces a woman's reproductive capability and increases the risks to subsequent children.¹⁹⁶

418. The Lane Committee commented that the Wynn report:

... referred largely to adverse effects said to result from termination of pregnancy: other evidence which was not quoted suggests that the incidence of late complications of therapeutic abortion was often no greater than the incidence following childbirth.¹⁹⁷

The Lane Committee report looks closely at the published research in this area.

419. Our research report also examined the published material. The conclusion is similar to that of the Lane Committee, that the evidence available is unsatisfactory

193. Mallen Committee report for 1975, p. 5.

194. *ibid.*, p. 6.

195. Evidence, pp. 182-290, Dr T. Hilgers; see also Evidence p. 1735, Dr Cockburn.

196. Margaret Wynn & Arthur Wynn, *Some consequences of induced abortion to children born subsequently* (Foundation for Education and Research in Childbearing, London, 1972).

197. Lane report, vol. I, p. 51, para. 140.

and does not support definite views one way or the other. The need is stressed for long-term prospective studies.

420. Although the research evidence is inconclusive in many respects it points to some factors which may have an important effect on the outcome of subsequent pregnancies. These effects would include: the legality of the procedure; the stage of the pregnancy; the experience of the operator; and the method of induction. Another factor may be the age of the woman concerned. The pregnancies most likely to end in abortion are those of young unmarried women and of older women with several children—groups predisposed to encounter more difficulties in pregnancy and childbirth. The use of abdominal methods at any stage of pregnancy is a factor which may predispose a woman to complications in later pregnancy and childbirth.

421. We note that the 1975 report from South Australia shows that 1.47 per cent of abortions were performed by hysterotomy as compared with 0.1 per cent of our sample (which included clinics who do not use this method at all). There is no significant evidence to connect abortion with sterility.

Conclusion

422. With many thousands of abortions now being performed in Australia it is vitally important for the women concerned, and for the medical practitioner, to be aware of any long-term risks and of ways of minimising those risks. When the WHO report is available it should be studied carefully and steps should be taken to modify medical procedures as necessary and to inform the medical profession and the patients of the situation to enable them to reach an informed decision. Depending on the results of the WHO report it may be necessary to mount a long-term study of abortion patients in Australia.

Psychological consequences of induced abortion

423. There are conflicting views about the psychological consequences of induced abortion. For example, Dr Hilgers said, on the basis of his experience, that:

There is little question in my mind that the legalisation of induced abortion does have psychological reactions in women.¹⁹⁸

On the other hand, Dr C. K. Churches said that:

. . . the number of patients who have guilt or depression afterwards is minimal.¹⁹⁹

424. In our 'open house' and 'phone-in' sessions we recorded a number of cases of women who regretted their abortion and felt guilt about it in later years. We also heard from women who felt regret at having given up a child for adoption. Childbirth itself can have adverse psychological consequences. A recent report on Preterm patients who completed a form within 2 weeks of their termination showed that only five (0.9 per cent) felt regret; four were undecided.²⁰⁰

425. One important factor affecting guilt, and possible mental disturbance which might flow from guilt, is the degree of acceptance that the community accords to abortion. In countries where abortion is performed clandestinely by unqualified or inexperienced operators in unsuitable conditions the emotional impact may be severe and may have lasting effects. By contrast, in countries where abortion is the main method of birth control the guilt element may be less severe. The attitudes of medical and nursing staff and of counsellors or social workers may be significant.

198. Evidence, p. 237, Dr T. Hilgers.

199. Evidence, pp. 2875–6, Dr C. K. Churches.

200. Snyder & Wall, p. 35.

426. Our research report shows that many of the studies, especially the early ones, used unsatisfactory methodology and that the conclusions may be affected by subjective factors.²⁰¹ Whereas there is considerable agreement among those working in the field of psycho-obstetrics as to the incidence of mental disturbance following childbirth, there is less agreement among those studying abortion.

427. Factors affecting subsequent mental health may include: age of patient; parity; length of pregnancy; socio-economic circumstances; marital status and marital adjustment; any subconscious motivations behind the pregnancy; whether the abortion is for psychosocial or medical reasons; the type of procedure used; community attitudes to abortion; the procedures involved in obtaining the abortion; and subsequent life situations.

428. The most recent studies pertaining to legal abortion indicate that, while there is frequently transient depression or feelings of guilt after abortion, there are seldom any significant long-term psychological after-effects. Opinions vary as to the effects of abortion where there is pre-existing mental illness; some find these patients are more at risk; some see it as not significantly affecting the existing situation; others see the abortion as genuinely therapeutic. There are likely to be few abortions carried out on women who have a serious mental illness. There may be some women who are unstable emotionally; these may be adversely affected by continuation of the pregnancy. If emotional instability is contributed to by the pregnancy, or if the pregnancy itself is the main cause of disturbance, abortion may bring about an improvement in the mental health of the woman.

429. Another factor which may affect the psychological outcome is whether the woman is able to make a free choice in full knowledge of the circumstances. If she is pressed to have or not to have an abortion this could enhance the prospects of later disturbance. The need for counselling is clear, particularly where a woman is ambivalent or is subjected to the pressures of family or friends.

430. The view of the Lane Committee was that:

... emotional distress is more likely in late abortions, after foetal movements have been felt and maternal feelings have been aroused. Operating procedures (e.g. saline induction) which involve a miniature labour are more likely than are other techniques to cause such distress.²⁰²

One study mentioned in our research report shows that depression rates may be high where abortion is performed because of suspected foetal abnormality, particularly where the child is wanted.²⁰³

431. Where abortion is accompanied by physical complications affecting future ability to conceive and give birth to wanted children, emotional consequences may be suffered. The likelihood of this occurring has not been established. There is some evidence that the psychological outcome may be less favourable where sterilisation is performed with abortion.

Conclusion

432. For some, perhaps many, women some feelings of remorse are inevitable after an abortion. It is not a procedure to be undertaken lightly or to be repeated. Where early abortion is carried out under appropriate conditions by competent and sympathetic operators there is no evidence that this will aggravate existing mental disturbance or lead to long-term psychological difficulties. It is important that a woman

201. Annexe IV.P, paras 204 ff.

202. Lane report, vol. I, para. 152 (7).

203. Annexe IV. P, paras 256-7.

contemplating abortion should have an opportunity to discuss any uncertainty she may feel before the operation and to talk over her feelings afterwards. Social workers, counsellors and doctors dealing with the post-abortion checks should be aware of the need which some women may have to ventilate their feelings.²⁰⁴

The psychological consequences of childbirth

433. The research report considers published reports on the effects of childbirth, showing that post-partum depression is a transient feature for many but lasts some time for a few women, up to a year in some cases. This factor needs to be considered in any discussion of abortion consequences. While it is not clearly established that the degree of depression is greater where the pregnancy was unwanted, negative attitudes seem to play a part. Young unmarried women appear to do less well psychologically both after an abortion or after childbirth than do older married women.

The consequences of failure to terminate pregnancy

434. The research report shows that, when legal abortion is refused, between one-third and one-half of the requesting women may find other means of ending their pregnancies.²⁰⁵ Of those who subsequently give birth to the child some give it up for adoption, but probably a greater number keep the child; single women are more likely to give a child for adoption than married women but even so a great many keep their children. Each of these outcomes has its effects on mother and child.

435. Among those who continue to term, a higher percentage appear to suffer psychological disturbance than those granted abortion. Where abortion is denied for medical or other reasons the woman may need counselling to help her to express her feelings, to come to terms with them and to decide whether to keep the child or to surrender it.

436. While adoption may be in the best interests of children in many cases, it can be emotionally damaging for their natural mothers. Where the mother decides to keep the child the fact that the pregnancy was not wanted has implications for the child's future. Research shows that the social well-being and both physical and mental health of children born of unwanted pregnancies, after refusal of abortion, are likely to be less favourable than for wanted children. This is not a necessary result: many children of unwanted pregnancies become wanted children, others do not.

Effects of abortion on the family

437. Under the UK Abortion Act 1967, the risk of injury to the health of existing children is a factor which may be considered in deciding whether abortion is to be permitted. The Lane Committee reported that the effect on children was a contributing factor in one-sixth of abortions. They also considered the effect on the woman's relationship with her husband or partner according to whether he agrees to the abortion, opposes it or urges her into it. Another factor they considered is that a woman may conceal an earlier abortion from her husband in a later marriage. These factors are potential causes of disharmony though the existence of an unwanted child may also cause problems.²⁰⁶

204. Dr Beverly Raphael, 'The psychosocial aspects of induced abortion', *Medical Journal of Australia*, 1 July 1972, pp. 35.-40, 8 July 1972, pp. 98-101.

205. Annexe IV.P, paras 279 ff.

206. Lane report, vol. I, pp. 54-5, paras 155-8.

438. We mention these matters because they underline the importance of counselling and of consulting the husband or partner where this seems appropriate. Dr Raphael points to the need to support other family members and to reassure the husband or partner.²⁰⁷

439. The Preterm report revealed that 84 per cent of the married women had told their husbands of the pregnancy; their reactions were said to be generally in favour of termination or in agreement with her decision. An unstable relationship may have been a factor leading to the decision to have an abortion. In the case of other women slightly fewer men were aware of the pregnancy but only 4.3 per cent were unsupportive. Where the woman was living with parents only 33 per cent of the parents were aware of the pregnancy, and most of these were supportive.²⁰⁸

Special risk groups

440. The Lane Committee identified categories of women who might need special attention in the delivery of abortion and after-care services. These include:

- girls under 16
- girls in care
- older or high parity women
- women who seek successive abortions²⁰⁹

441. A number of girls under 16 are obtaining abortions in Australia. In the Preterm study of 1007 women, sixty-two (or 6.2 per cent) were 16 or under.²¹⁰ The South Australian reports for 1974 and 1975 show eighty-nine (4.03 per cent) and ninety-one (3.12 per cent) girls under 16 respectively. In our own survey 4.6 per cent (129) were under 16; this compares with 2 per cent in England in 1971.²¹¹

442. Dr Cleary drew our attention to this group, suggesting a greater risk of complication, especially in a first conception.²¹² There is some evidence to suggest that this group has a higher morbidity rate and a higher rate of later complications.²¹³

443. One problem is that these young girls may find it difficult to obtain advice until the pregnancy is well advanced, or they may deny the pregnancy. This is thought to contribute to the high percentage of second trimester abortions among teenagers.²¹⁴ This procedure is more risky for this age group.²¹⁵ There is also a risk of a further unplanned pregnancy. These factors point to the need for better information and education for young people and for special attention to counselling at the time of abortion.

444. In the case of older or high parity women, we have seen that the proportion of abortions to live births increases dramatically with ages over 35 and with greater numbers of children. The complications of pregnancy and childbirth are greater for these women and also the possibility of a handicapped child being born. The risk of death or complication in abortion is also higher and this is something which the woman should be aware of in making her decision.

207. Raphael, *MJA*, 1 and 8 July 1972.

208. Snyder & Wall.

209. Lane report, vol. I, p. 72.

210. Snyder & Wall, p. 6.

211. Lane report, vol. I, p. 74, para. 221.

212. Evidence, p. 1238, Dr E. G. Cleary.

213. Lane report, vol. I, paras 227-9.

214. 'Mid-trimester abortion and its complications', *MJA*, 22 January 1977, p. 82.

215. *ibid.*, quoting A. F. Connon, *Obstet. Gyn. Digest* 17, 3 (1975).

445. The Preterm report showed that 122 women (12.1 per cent) had had at least one abortion, including twenty-nine who had two or more previous abortions.²¹⁶ This compares with 17 per cent in our study. The Lane Committee stressed the need for counselling and contraceptive advice for these women²¹⁷; the possibility of sterilisation should also be considered for those whose family size is complete.

Conclusions

446. A recent report in the *Medical Journal of Australia* summed up the position as follows:

It is now widely accepted, on the basis of sound statistical evidence, that termination of pregnancy in the first 8 weeks of gestation is a safe medical procedure. Improved anaesthesia, including the use of local anesthesia, and new technology applied in instruments such as the slim, flexible suction catheter/curettes have made induced abortion a safe day-case procedure in skilled hands. Careful selection of cases, standardisation of operative technique and appropriate counselling and support with follow-up have made termination of pregnancy a simple procedure with minimal morbidity and no mortality.²¹⁸

Our own analysis of published research studies bears this out, as does our survey of hospitals and clinics. The relaxation of abortion laws and the increasing trend for abortions to be performed in hospitals or free-standing clinics by medical practitioners who have developed expertise in the procedures have helped to reduce mortality and morbidity. The current rates in Australia are low and would be lower if the number of second trimester abortions were reduced.

447. We find nothing in the studies we have considered to change our view that legal restrictions should not be imposed on abortion on account of any risk of complication. There are, however, a number of important factors which should be understood by women contemplating abortion and by doctors and others involved in abortion.

448. If abortion is considered necessary it should take place as early as possible in the pregnancy. The risks of second trimester abortions are greater. For this reason there should be no administrative delays in arranging or performing the operation. The facilities for performing abortions should be improved and expanded and information about the facilities should be readily available to every woman who may seek an abortion. The risks of delay should be known as widely as possible.

449. Sterilisation in association with abortion, and abdominal methods should be avoided. All women seeking abortion should have access to counselling before and after the procedure. Special attention to counselling and contraceptive advice should be given to women in high risk groups.

450. There are real difficulties in obtaining reliable information and comparing published material about the complications of abortion. This has been noted by the Lane Committee, by the South Australian Committee²¹⁹ and by a recent comment in the *Medical Journal of Australia*.²²⁰ The Lane Committee's view was that all reports of morbidity should:

... be classified and defined in the same way, giving the method used and the incidence and degree of severity of the complications which occurred.²²¹

216. Snyder & Wall, p. 9.

217. Lane report, vol. I, para. 273.

218. 'Mid-trimester abortion and its complications', *MJA*, 22 January 1977, p. 82.

219. Mallen Committee report for 1975, p. 6.

220. 'Mid-trimester abortion and its complications', *MJA*, 22 January 1977, p. 83.

221. Lane report, vol. I, para. 125.

The others called for more systematic and uniform notification of the complications of abortion. The South Australian Committee called for compulsory notification of complications of abortion. We would not go so far, as this tends to differentiate abortion from other surgical procedures to an unacceptable extent.

451. There is, nevertheless, an important public interest in ascertaining accurate information about abortion and its complications over a period of time. There would be advantages if a standard form could be agreed for recording this information for the purpose of the patient's medical record and for research. The formula adopted in our own research project is proposed for this purpose.

452. The results of our own survey have not yet been fully analysed. We consider that this should be undertaken as soon as possible to provide information about the complications of abortion and the factors which contribute to those complications.

Attitudes to abortion

453. Our terms of reference require us to inquire into and report on:

. . . the adequacy and effectiveness of existing medico-legal determinations in relation to termination of pregnancies.

It is relevant to our own consideration of these matters and to any political decision about a change in the law to have regard to public attitudes. We present in this section information about current public opinion in Australia and we also refer to opinions in the United States and the United Kingdom.

454. Abortion is a subject about which people tend to have firmly held and conflicting views. In pursuing our inquiry we have tried to avoid distortion which may arise from the strongly expressed opinions of special interest groups. It has been our aim to present findings which are broadly representative of the views of all Australians and which do not reflect only the views of those who are most articulate or best organised. There have been strong lobbies on both sides of the abortion issue and reconciliation of views is difficult. It is of particular importance to have regard to public opinion, so far as it can be ascertained, in order to determine the extent to which the population as a whole is polarised in its views or in broad agreement.

455. Public attitudes have several implications for abortion law. First, the views held by people as to the circumstances in which abortion should be permissible, on the one hand, or punishable, on the other hand, are clearly important to the legislator. Secondly, if the majority do not accept that abortion laws should be enforced then those laws lose their validity, become unenforceable in practical terms and fall into disrepute.

456. Public opinion does not necessarily conclude the debate on the legal and moral issues of abortion, especially where extreme views are strongly held by opposing groups. Nevertheless, account should be taken of a broad consensus of views of the less vocal majority. It is these views which are revealed by the surveys and polls outlined in this section.

Australia

457. Four surveys on the attitudes of the Australian public to abortion were examined by the Commission. These were:

- (a) Australian attitudes towards abortion. The data for this survey were obtained as part of the Australian Family Formation Project study conducted by the Demography Department of the Australian National University.²²²

222. J. Caldwell & H. Ware, 'Australian attitudes towards abortion', *Abortion: repeal or reform* (Australian National University, Centre for Continuing Education, Canberra, 1972).

- (b) A poll conducted for the *Age* newspaper, results of which were published in the *Age* on 11 November 1976.
- (c) Morgan gallup polls between 1973 and 1974.
- (d) A national opinion poll commissioned by Simon Hasleton of the Department of Psychology, University of Sydney.

458. The results of surveys of public opinion about abortion must be approached with some caution. In the first place, such polls are usually regarded as less reliable than surveys based on random sampling procedures. In this case, similar trends have been picked up by all the polls and surveys mentioned, suggesting that the trends reported reflect the distribution of opinion in Australia.

459. Another difficulty in analysing results is that questions and answers do not always distinguish clearly between moral and legal issues. For example, the response to the following questions might be different:

Is abortion on demand always justified?

Should a doctor be penalised for performing an abortion?

Those who consider that a medical practitioner should decide upon and perform abortions may not agree that a woman should have the right to insist on an abortion, while nevertheless accepting that the doctor should not be subject to criminal sanctions in the exercise of his discretion. This factor needs to be kept in mind when considering the surveys.

460. Interpretation of results must take into account the wording of the question and the context in which the question is placed. Thus the response varies according to the question asked. While many cannot agree that abortion should be available 'on demand', listing of each possible reason for abortion finds community acceptance of psychological and social reasons for abortion. Further, a question about abortion placed in the context of rape, child abuse or family breakdown may elicit a response differing from that obtained from the same question placed in the context of population growth.

461. A survey of family formation attitudes and practices, conducted by the Department of Demography of the Australian National University, in Melbourne and Queanbeyan in 1971 provides many illustrations of the above points. This survey interviewed all married women under 60 years of age in each selected dwelling who had been only once married and were still living with their husbands. There were 2648 respondents in Melbourne and 244 in Queanbeyan. Caldwell and Ware report that:

Successive questions in the metropolitan survey on the legalisation of easily available abortion in the developing countries and in Australia yielded 61 per cent support for easy legal abortion in countries such as India and 53 per cent support for such a measure being introduced into Australia. The actual gulf may well be wider, for the demonstration of possible inconsistency by the juxtaposition of the questions almost certainly served to raise the Australian figure.²²³

They also found that the first mention of abortion in an interview often provoked an emotional reaction to the word abortion itself. It emerged that respondents who rejected the original proposition that women should be allowed by law to have an abortion in some circumstances redefined their views when more detailed questions were put to them.

Some 16 per cent of the metropolitan respondents at first said that the law should not allow abortion in any circumstances, but only 10 per cent would deny a legal abortion to a woman made pregnant by rape, and only 9 per cent to a woman whose physical health was endangered by the pregnancy.²²⁴

223. *ibid.*, p. 46.

224. *ibid.*, p. 52.

Table IV.37 Melbourne survey, 1971. Responses to a range of questions concerning the legal control of abortion

| | | Yes | Qualified yes | No | Qualified no | No response | Total ^(a) |
|-------------|--|-----|------------------|----|-----------------|----------------|----------------------|
| Q.147 (a) | Regardless of whether you yourself would ever consider having an abortion, do you think that a woman should be allowed by law to have an abortion in some circumstances? | 65 | 14 | 16 | 4 | 1 | 100 |
| Q.148 A | Should abortion be allowed by law? If the woman has been raped? | 80 | 5 | 10 | 2 | 3 | 100 |
| Q.148 D | Should abortion be allowed by law? If the birth would endanger the woman's physical health? | 79 | 6 | 9 | 3 | 3 | 100 |
| Q.149 (a) | If abortion were allowed by law, can you imagine any circumstances in which you might have an abortion? | 30 | 17 | 48 | 2 | 3 | 100 |
| Q.169 (a) 4 | In the crowded countries of the world, do you favour the government discouraging parents from having more than two children by changing the law to permit women to have abortions? | 61 | .. | 34 | .. | 5 | 100 |
| Q.169 (b) 4 | Now, in Australia, do you favour the government discouraging parents from having more than two children by changing the law to permit women to have abortions? | 48 | 5 ^(b) | 43 | .. | 4 | 100 |

(a) Total respondents = 2652 women

(b) 'Not at present but in the future.'

Source: J. Caldwell and H. Ware, 'Australian attitudes toward abortion', *Abortion: repeal or reform* (ANU, Centre for Continuing Education, Canberra, 1972).

462. A recent poll conducted by the *Age* newspaper indicated that between 1973 and 1976 Australian tolerance of abortion on request has increased markedly. In both years the *Age* poll interviewed 2000 people of voting age in the six States and the ACT. The sample covered every federal electorate except the NT. Results of the 1976 survey are summarised in table IV.38.

Table IV. 38

| | Total 2 000 | Male 998 | Female 1 002 | Aged 21-24 180 | Aged 60 & over 368 | University educated 184 | Primary educated 243 |
|-------------------------|----------------|-------------|-----------------|----------------------|--------------------------|-------------------------------|----------------------------|
| | % | % | % | % | % | % | % |
| Abortion on request is: | | | | | | | |
| Right-harmless | 46 | 47 | 44 | 49 | 38 | 55 | 33 |
| Wrong-dangerous | 34 | 33 | 35 | 29 | 40 | 27 | 46 |
| Neither-don't know | 21 | 20 | 21 | 22 | 22 | 18 | 21 |

Note: Percentages rounded to nearest whole numbers.

Source: *Age* poll, *Age*, 11 November 1976, p. 4.

463. In 1973, 35 per cent of respondents said that abortion on request was right or harmless. In 1976, this had increased to 46 per cent of respondents. In July 1973, 39 per cent of respondents thought abortion on request was wrong, today only 34 per cent think so.²²⁵ In the Melbourne survey of 1971, 27 per cent agreed that abortion should be allowed by law whenever the woman asks for an abortion. Of those who said no, many remarked that a woman should have a doctor's agreement.

464. In August-September 1973, an Australia-wide probability sample of 2153 men and women aged 14 and over were asked to choose one statement out of five that came closest to their opinion. Results are summarised in table IV.39.

Table IV.39 Choice of statement closest to opinion

| Statement | Percentage of respondents agreeing |
|---|--|
| (1) Abortion should not be legal in any circumstances | 8.2 |
| (2) Abortion should be legal only if the mother's life is in serious danger | 15.7 |
| (3) Abortion should be legal if the mother's health, either physical or mental, is in danger | 23.7 |
| (4) Abortion should be legal in cases of exceptional hardship either physical, mental or social | 21.8 |
| (5) Abortion should be legal in all circumstances, that is 'abortion on demand' | 22.9 |
| (6) No opinion | 7.6 |

Source: Morgan gallup poll, no. 9, 25 August-1 September 1973.

Over 66 per cent of respondents were in favour of the relaxation of laws relating to abortion.

465. In November 1974 a gallup poll found that, to the question:

Should an abortion for a woman who has had medical and social counselling be legal or illegal? 68.8 per cent of respondents answered legal and only 20.3 per cent answered illegal.²²⁶

225. *Age*, 11 November 1976, p. 4.

226. Morgan gallup poll, no. 51, 23-30 November 1974.

466. In August 1973 Simon Hasleton, of the Department of Psychology at the University of Sydney, commissioned Australian National Opinion Polls Pty Ltd to present a group of ten statements about permissiveness in Australian society to a stratified random sample of the Australian electorate. The sampling frame selected subjects at random from the Commonwealth electoral roll, within electoral divisions selected on the basis of a series of social and political indicators. Persons ineligible to vote, e.g. immigrants, were not involved in the survey. Sampling took place in the whole Commonwealth with the exception of the NT and the ACT. A total of 2410 subjects were empanelled and 1881 actual interviews were conducted. The question on abortion was:

Do you agree or disagree that a woman should be free to have an abortion in the first 3 months of pregnancy without risking prosecution?

The results are set out in table IV.40.

Table IV.40 Percentage response to question on abortion in first 3 months of pregnancy

| | Agree strongly | Agree mildly | Don't know | Disagree mildly | Disagree strongly |
|--------|-------------------|-----------------|---------------|--------------------|----------------------|
| | % | % | % | % | % |
| Male | 48.6 | 22.1 | 3.4 | 7.3 | 18.5 |
| Female | 45.0 | 20.7 | 3.9 | 6.5 | 23.9 |

Source: Original data from Simon Hasleton.

The poll found that 47 per cent of men and women surveyed agreed strongly with the proposition and a further 21 per cent agreed with it making a total of 68 per cent in agreement. Only 4 per cent said they did not know; 7 per cent disagreed mildly and 21 per cent disagreed strongly, making a total of 28 per cent who disagreed with this statement. Men were slightly more in favour of the proposition than women.²²⁷

467. In the 1971 Melbourne survey the respondents were asked the following question:

Regardless of whether you yourself would ever consider having an abortion, do you think that a woman should be allowed by the law to have an abortion in some circumstances?

The results summarised in table IV.37 show that 16 per cent answered 'no' and 4 per cent qualified their 'no' answer. This demonstrates that adamant opposition to any legalisation of abortion in Australia was maintained by no more than a sixth of the sample.²²⁸

468. The Melbourne survey shows that support for the liberalisation of abortion laws is strongest among the better educated upper socio-economic groups of society.²²⁹ The poll conducted for the *Age* showed a similar pattern. Fifty-five per cent of those with university education said abortion on request was either right or harmless as opposed to only 33 per cent of those with primary education (see table IV.38). Successive polls taken in the United States during the 1960s and 1970s also showed this trend.²³⁰

227. S. Hasleton, 'Permissiveness in Australian society', *Australian Journal of Psychology* 27, 3 (1975), p. 260.

228. Caldwell & Ware, p. 43.

229. *ibid.*, p. 45.

230. W. R. Arney & W. H. Trescher, 'Trends in attitudes towards abortion, 1972-75', *Family Planning Perspectives* 8, 3 (1976), pp. 119-20; J. Blake, 'Abortion and public opinion: the 1960-1970 decade', *Science* 171 (1971), p. 543.

469. Caldwell and Ware attribute this pattern to several factors:

Firstly, this group because of their greater literacy and contact with the world outside their home are more likely to meet new ideas earlier. Secondly, their background and their way of life makes them generally feel that they should control their own lives more . . . The richer are apparently more concerned with the economic problems of large families than are the poor.²³¹

470. Roman Catholics who have received more than 12 years of education are the exception to this pattern:

This group consistently show themselves to be more opposed to abortion than their co-religionists of lower education, a trait which is presumably a reflection of their greater awareness of the teachings of their church.²³²

471. The survey showed that Catholics in general were more opposed to legalised abortion than non-Catholics. In Melbourne 65 per cent of active Catholics supported legalisation in some circumstances as compared with 90 per cent of the rest of the community. However:

. . . a substantial majority of Catholics of all backgrounds favoured legalised abortions in some circumstances and most in more circumstances than are now allowed in all Australian States except South Australia.²³³

472. There is greater opposition to abortion among southern European migrants than other Australians. The practice of abortion by this group is, however, relatively common. Caldwell and Ware believe that the attitudes of this group are explained by cultural tradition as well as religion and are closely related to very low educational standards of the majority of southern European migrants.²³⁴

473. The Queanbeyan and Melbourne surveys found that there was virtual uniformity of views concerning the mother's physical and mental health, rape and deformation of the child as legitimate grounds for abortion. Twenty-five per cent opposed abortion on the grounds of the youth of the mother, 38 per cent opposed it on the grounds of illegitimacy and the least acceptable case was abortion on demand which was rejected by 65 per cent of the respondents.

United States

474. During the 1960s and early 1970s virtually identical public opinion surveys found that the majority of Americans approved of abortion on the grounds of the health of the mother, rape or deformity of the baby. However, although support for elective abortion was steadily increasing in those years, in no year did abortion on the grounds of poverty of the parents, family planning reasons and illegitimacy obtain approval from as many as half of all the respondents to any survey.²³⁵

231. Caldwell and Ware, p. 86.

232. *ibid.*, p. 73.

233. *ibid.*, p. 43.

234. *ibid.*, p. 82; see also chapter on migrants in Part VI of this report.

235. J. Blake, 'Elective abortion and our reluctant citizenry: research on public opinion in the United States', in H. J. & J. D. Osofsky (eds), *The abortion experience: psychological and medical impact* (Harper and Row, NY, 1973), p. 449; Arney & Trescher, p. 118; E. F. Jones & C. F. Westoff, 'Attitudes toward abortion in the United States in 1970 and the trend since 1965', Commission on Population Growth and the American Future, Research reports, vol. I, *Demographic and social aspects of population growth*, p. 572.

Table IV.41 Percentage of respondents approving of abortion for each of six reasons, by reason and year of survey, 1972–75, United States

| Reason | 1972 (N = 1 613) | 1973 (N = 1 504) | 1974 (N = 1 484) | 1975 (N = 1 490) |
|------------------|---------------------|---------------------|---------------------|---------------------|
| Mother's health | 83 | 91 | 90 | 88 |
| Rape | 74 | 81 | 83 | 80 |
| Defect in child | 74 | 82 | 83 | 80 |
| Family poor | 46 | 52 | 52 | 50 |
| Mother unmarried | 40 | 47 | 43 | 46 |
| No more children | 38 | 46 | 45 | 44 |

The 1973 survey was taken 2 months after the Supreme Court decision.

Source: W. R. Arney & W. H. Trescher, 'Trends in attitudes towards abortion, 1972–75', *Family Planning Perspectives* 8, 3 (1976), p. 118.

United Kingdom

475. In the United Kingdom the Committee on the Working of the Abortion Act examined the results of opinion polls conducted on behalf of various research centres, newspapers and organisations and concluded that:

... before 1967 public opinion was strongly in favour of a liberalisation of abortion laws. Since 1965 the proportion totally opposed to abortion has fallen from 24 per cent (National Opinion Poll, 1965) to between 6–9 per cent (Opinion Research Centre, 1971). However, in spite of this change in attitude 42 per cent of respondents in 1970 thought abortion morally wrong (NOP for *Daily Mail*, 1970) and this response highlights the inconsistency between attitudes to morals and to practice. The proportion of persons advocating abortion 'whenever the mother wants' has risen from 6 per cent in 1965 (NOP, 1965) to between 15 and 20 per cent in 1971 (Harris, ORC, 1971).

It appears, however, that about three-quarters of the population are prepared to agree to abortion in special circumstances, and there is a clear majority in favour of abortion in the following specified instances:

- (a) when a mother is or would become either physically or mentally ill;
- (b) when the baby is likely to be deformed;
- (c) when the pregnancy is the result of rape;
- (d) when the pregnancy is the result of incest.²³⁶

476. In Britain, despite intensive publicity campaigns with major public demonstrations, public attitudes are becoming increasingly liberal. National opinion polls in April 1975 and in April 1976 interviewed a representative quota sample of 1050 electors in fifty-two parliamentary constituencies throughout Great Britain. The results are summarised in table IV. 42.

236. Lane report, vol. II, p. 23.

Table IV. 42 National Opinion Poll survey about attitudes to abortion, 1976. Do you agree or disagree with the following statement: 'Abortion should be made legally available for all who want it'?

| | April 1976 % | April 1975 % |
|----------------------------|--------------------|--------------------|
| Agree very strongly | 11 | 5 |
| Agree strongly | 12 | 9 |
| Agree | 32 | 38 |
| Neither agree nor disagree | 14 | 14 |
| Disagree | 14 | 25 |
| Disagree strongly | 10 | 5 |
| Disagree very strongly | 7 | 4 |

Source: National Opinion Poll survey about attitudes to abortion, Great Britain, 1976.

Conclusion

477. The Australian surveys, especially those of the Australian Family Formation Project, make it clear that in Australia, while there remains a polarisation of extreme views, there is also a high level of consensus. A majority of all major groups—even many Catholics—approve of the further legalisation of abortion. It is also clear that many people do not see abortion in simple absolute terms of right and wrong. Australians take physical, emotional and social circumstances into account when deciding whether abortion is permissible or not.

478. A final comment on the analysis of the surveys is that they have taken place against a background of important changes in the law and practice of abortion. Heated debate, emotional expression of views and widespread publicity for both sides of the issue accompanied these moves. The history of the reform of abortion law in South Australia, the way in which the reform campaign was mounted and the part played by public opinion polls are described in 'The Abortion Law Reform Association of South Australia: 1968-1973'.²³⁷ Public opinion over this period shows a steadily increasing trend towards support for liberalised abortion.

237. J. Mercer (ed.) *The other half: women in Australian society* (Penguin, Melbourne, 1975), pp. 377 ff.

5. Young people and fertility control

1. In this chapter we look at some aspects of the sexual behaviour of young people, the risks which are involved and the need for specific programs to promote responsible sexual behaviour. By 'young' people we mean broadly young single people under 25, but our main emphasis is on the under 20s—the 'adolescents' or 'teenagers'.
2. Throughout this report we have referred to aspects of sexuality and fertility control of special relevance for young people. The facts can be summarised briefly:
 - (a) There is a level of teenage sexual activity which cannot be ignored.
 - (b) Young single people have a low rate of effective contraception.
 - (c) A very high proportion of unwanted pregnancies and abortions occur to teenagers.

Level of adolescent sexual activity and pregnancy

3. We planned a research project to survey the sexual knowledge, attitudes and behaviour of young people, but this project did not proceed.
4. An interest in the opposite sex develops for many young people at the time of puberty when few young people are ready to take on the social and economic responsibilities of adulthood.
5. Research among Australian university students and student teachers shows that 60 per cent of the males had sexual experience before 20 and about 10 per cent by the age of 16.¹ The percentages of girls having sexual experience at those ages are lower.
6. Research in England and in the United States shows that a pattern of sexual activity begins for a small minority under the age of 16.² Michael Schofield's study of London teenagers found that 11 per cent of boys aged 15–17 and 30 per cent of boys aged 17–19 had experience of sexual intercourse. The percentages for girls were lower (6 per cent and 16 per cent).³ He points out that sex experience follows a progression through various stages, each stage being either an end in itself or a stepping stone to the next level.⁴ First experience of intercourse took place for nearly half the group in the parental home of the partner (who was often older and experienced).⁵
7. The circumstances in which these early sexual experiences occur contribute to the low level of contraceptive use among young people. Many young people are unprepared; unaware of the issues, of their own responsibilities in sexual behaviour and how to exercise them. Other important factors are ignorance and difficulty in obtaining information, advice or contraceptives.
8. Although only a minority of teenage girls have pre-marital sexual experience, teenagers are responsible for a relatively high proportion of ex-nuptial births and abortions. Among women under 20 there were 26 296 live births in 1974 in Australia (10.7 per cent of the total live births). These included 9610 ex-nuptial births (36 per cent of the total births to those under 20). In addition, if our estimates are right, there are about 18 000 teenage abortions each year (30 per cent of the total number of abortions).

1. Beighton & Cole, Commission research report, no. 5; Submission 572, P. Chopra and W. Warren.
2. Schofield, 1968; Zelnick & Kantner in *Demographic and social aspects of population growth*.
3. Schofield, pp. 45–6.
4. *ibid.*, p. 51.
5. *ibid.*, pp. 64–5.

9. The rate of live births to unmarried women under 20 showed a steady increase up to 1972 and then declined slightly.⁶ The actual number of ex-nuptial births to all women also increased up to 1972 (25 659), but was a little lower in the following 2 years (1974: 23 408).⁷ One possible explanation for this is that fewer pregnant girls married before the birth of the child.⁸ There are cultural differences in this pattern; southern European immigrants show much lower rates of illegitimacy and of first births within marriage which had been pre-maritally conceived.⁹

The risks of sexual activity

Pregnancy

10. The main risk of sexual activity among adolescents is pregnancy. The problems of pregnancy and abortion in adolescents were studied by a WHO meeting which concluded that they had been ignored in the past as a special issue; the meeting called on all countries to acknowledge the needs of adolescents and to develop programs to meet them.¹⁰

11. The outcomes of an unwanted pregnancy to a girl under 20 can be disastrous and can affect her whole future. Her education may be interrupted and with it her ability to become independent unless there is opportunity for her to continue with her schooling.¹¹

12. If the girl gives birth to an ex-nuptial child her prospects do not improve. Surrendering the child for adoption is one option which is often beneficial for the child. It sometimes works out well for the mother, though the experience of pregnancy, childbirth and surrender may cause substantial stress. If the mother keeps the child her chances of marriage may be diminished. The financial circumstances of a lone parent family can be difficult. The equality now often given to ex-nuptial children in law does not ensure that such children have equal opportunities in life.

The pregnancy may precipitate an early marriage.

Very young brides aged less than 20 years are most likely to be pre-maritally pregnant, particularly if the bridegroom is also less than 20 years of age.¹²

These marriages run a high risk of breakdown and divorce with consequent hardships to the couple and the child and to any further children born to them.¹³

13. The Rev. P. J. Hollingworth made the following observation, based on the experience of the Brotherhood of St Laurence youth program:

It is most unusual for a boy and a girl to go together and to get married without the girl being pregnant. For most young people there is no sense in which they are able to shape their lives or plan their families. They are largely victims of inner libidinal drives and environmental/cultural pressures.¹⁴

14. Pregnancy and childbirth may present additional health risks for adolescents, particularly to the under 16s, though this is not firmly established. The psychological stress of coping with unwanted pregnancy may be an additional cause of complications.

6. L. T. Ruzicka, 'Fertility decline in Australia—emerging new strategy of family formation', in *Towards an understanding of contemporary demographic change*, Australian Family Formation Project, Monograph no. 4, pp. 13–15.

7. ABS.

8. Ruzicka, p. 15.

9. *Towards an understanding of contemporary demographic change*, p. v.

10. *Pregnancy and abortion in adolescence*, report of a WHO meeting, Technical Report Series, no. 583 (WHO, Geneva, 1975), p. 25.

11. Evidence, p. 1421, Robyn Harnett.

12. Ruzicka, p. 15.

13. Evidence, pp. 823–4, J. Krupinski.

14. Hollingworth, *Australian Family Physician* 2 (1973).

15. Abortion is chosen as a solution by many—up to 18 000 teenage pregnancies each year end in abortion. While abortion is not necessarily more risky for the teenager than the older woman, it may in practice be more so in many cases because of the delay in seeking advice.

Other risks

16. There are other health risks involved in early sexual experience. Some of our submissions spoke of an established association between early sexual intercourse and promiscuity in adolescence with the later development of carcinoma of the cervix.¹⁵

17. Venereal disease is another hazard, especially in casual and changing relationships. Young people are particularly vulnerable due to ignorance and the failure to use contraception.¹⁶

The need for action

18. The pattern of adolescent sexual behaviour seems to have changed, though perhaps less markedly than some may think. There has always been sexual experimentation among the young, pre-marital sexual relationships, ex-nuptial births and abortions. The reducing age of maturity, increasing opportunities for sexual relationships, the desire for personal autonomy and the weakening of social controls may contribute to an increased incidence of pre-marital intercourse and early sexual experience. Adolescents form their behaviour patterns within the framework of their own society. One of our submissions commented that if society condones blatant display and emphasis of sexuality in advertising and encourages emphasis on sex it cannot hope to prevent an increased desire of the young to experiment.¹⁷

19. Margaret Mead commented on the dating pattern and its effect on adult relationships as follows:

We permit and even encourage situations in which young people can indulge in any sort of sex behaviour that they elect. At the same time we have not relaxed one whit our disapproval of the girl who becomes pregnant, nor simplified the problems of the unmarried mother who must face what to do about her child. We disapprove of abortion, and adequate and available birth control information is almost impossible to obtain.¹⁸

20. Another point made by Margaret Mead is that, if the restrictive pattern imposed on teenage sexuality is adopted, it may lead to inhibitions and sexual problems in later life.

21. If young people are ignorant of their bodies and of themselves they will be at risk. There is a danger in adopting the attitude that teenage sexuality does not exist or that it can be prevented.

22. A young person's sexuality and growing sexual awareness is a continuing process; attitudes and beliefs acquired when young shape the pattern of life. If young people are told or learn from silence or disapproval that sex is wrong or dirty or unmentionable this will influence their outlook and possibly their ability to achieve sexual fulfilment.

23. There are many people who believe sincerely that to acknowledge and accept teenage sexual behaviour and to extend contraceptive services to young people is to invite and even to encourage promiscuity and immorality. A view typical of many put

15. Submission 1101, AMA.

16. Evidence, pp. 1600–10, B. Smithurst; Exhibit 103.

17. Submission 1004, Petah Battersby.

18. Margaret Mead, *Male and female* (Penguin, Harmondsworth, 1950), p. 266.

to the Commission is that extension of contraceptive services to the young would be permissive, would tend to lower the priority of marriage and remove the responsibility of parenthood.

24. We do not believe that this is a majority view. In an opinion survey analysed for the Commission by Simon Haselton, 65 per cent approved of contraception for those over 16.¹⁹

25. The fears of teenage promiscuity seem to us to ignore the reality of what is happening now, the fact of adolescent sexual behaviour, the low level of contraception and the urgent need to protect young people from the risks to which they are so vulnerable. Providing young people with education, information and services may reduce these risks and it has not been proved that it will lead to experimentation. Professor I. C. Lewis of Hobart said that to increase knowledge does not necessarily lead to the risk of experimentation, but 'careful handling' is needed. 'It is necessary to learn the pattern and modify it.'²⁰

26. Unless venereal disease, pregnancy and abortion are seen as just punishment for sexual activity the need for some form of special assistance will not disappear. Ignorance is no protection, it compounds the risks of sexual experimentation.

27. In our view, action needs to be taken at several levels. First, it is necessary to increase the awareness of young people about sexuality and human relationships and to develop in them the ability to make responsible decisions about their own behaviour and its consequences. Secondly, we need to think whether special services are needed to reach out to young people. Thirdly, it is necessary to remove the barriers which prevent the young from receiving effective information and advice when they most need it.

Education, information and motivation

28. We have already emphasised the need for broadly based education in human relationships and sexuality. High school programs should introduce information at an early age about conception and contraception and about contraceptive services. Information pamphlets about community resources should be distributed widely and especially to young people.²¹

29. An interesting way of getting the message to young people is through comics. In England the FPA published a comic *Too great a risk!* and the Wandsworth Centre for Community Relations published *Don't rush me!* These convey a message about sexual behaviour and contraception in the context of a relationships story, e.g. in *Don't rush me!*:

Rita thinks she has lost her boyfriend Errol because she refused to sleep with him. She discusses her dilemma with other girls . . . Various points of view are raised including that of the boy, and she is given factual information on birth control.

These comics are aimed at 14–16-year-olds. Ideas of this kind should be studied and adopted. The accent should be on motivation and on the development of personal awareness and responsibility in relationships: to act with concern for themselves and others in knowledge, not in fear and ignorance.

19. Hasleton, Commission research report, no. 6, p. 10.

20. Evidence, p. 2315, Prof. I. C. Lewis.

21. French project on women, *Projet pour les femmes 1976–1981*, pp. 57–9; see also *What you should know* (University of Hawaii) referred to in Submission 905, FPA, Tasmania; the VD comics referred to in chapter 1 of this part.

Services for young people

30. How well do existing contraceptive services meet the needs of young people? Some general practitioners are reluctant to give contraceptive advice or services to young girls and boys without parental consent. While the better educated, more sophisticated teenager may know or find out what to do or where to go for advice on contraception, some young people are fearful of disapproval, too shy to approach their doctor or simply do not know where to go. They are very often financially dependent on their parents and unable to pay for services or supplies. The legal position regarding contraceptive advice to minors is considered below.

31. The Family Planning Association gives information and advice to young people. Because of its name and history young people may be reluctant to approach it even if they know about the FPA. One young person wrote to the Commission:

I am only 15 and haven't much brains but I think that a good idea would be for the government . . . to set up a postal contraceptive service for people who are too shy to attend family planning clinics or ask their chemists or doctors.²²

32. Most FPAs now run special clinic sessions for young people. An example is 'Network', a drop-in centre organised by the FPA in Adelaide as a Saturday morning drop-in centre for teenagers. Young counsellors are on duty to advise about contraception and sexuality problems:

'Network' is young people talking with young people about getting on with the opposite sex.

33. The Commonwealth government recently made funds available to the Family Planning Association of Victoria to establish an Action Centre for adolescents and adults. The centre is based on the Brook Advisory Centres;²³ Teen Clinics also operate in the United States.²⁴ The Action Centre provides counselling and information on birth control, personal and family relationships, sexuality, marriage, behaviour and development, pregnancy testing and VD. It offers a telephone service. The Centre is located in the centre of Melbourne; it is open every weekday and Saturday mornings and the service is free. Reports on the first 8 weeks' activities, from 12 December 1976 to 30 January 1977, show that a wide range of subject matter was dealt with. Contraceptive advice seems to be the service most sought after. In our view a service of this kind is much needed and should be extended to other cities and main centres. The idea of involving young people in planning and service provision is very much in keeping with our view that users of special services should be consulted and involved.

34. Clinic and other services based in one location, however good they are, depend for their impact on a good advertising information service to inform people of their existence and the service they offer. They also suffer from the fact that they must be centrally located and are inaccessible to many. Some young people are unaccustomed or unwilling to approach anything so organised.

35. Professor Lewis thought that there might be too much emphasis on clinic services and that more thought should be given to reaching people who need services.²⁵ A precedent for a service which goes out to meet young people in their own environment

22. Submission 1023, name withheld.

23. J. Medawar and D. Pyke (eds) *Family planning* (Penguin, Harmondsworth, 1971), pp. 187-8. The Brook Advisory Centres in the UK were set up to give young people 'professional advice on scientific methods of contraception, birth control and family planning and on physical and emotional problems arising from the relationships between the sexes'.

24. S. Goldsmith, 'San Francisco's Teen Clinic', *Family Planning Perspectives* 1, 2 (1969), p. 23.

25. Evidence, pp. 2259 ff, Prof. I. C. Lewis.

is provided by the Family Planning Association in London. 'Grapevine' was set up to discover ways of making health and sex education widely available to young people who do not approach 'establishment' organisations.

36. Young volunteers, aged 16–30, are trained to make regular visits to places such as coffee bars where young people can be contacted, information exchanged, and befriending/counselling offered to those with problems. In a report on the service, the different kinds of need were defined as follows:

- (1) young people wanting straight information about birth control, VD, sexuality, relationships, etc;
- (2) young people wanting befriending, help in making relationships with the opposite sex, discussion of values and beliefs etc. (e.g. what is meant by promiscuity?);
- (3) young people undergoing some temporary crisis, most of whom probably need a sympathetic listener, factual information and personal support over a short period;
- (4) young people who suspect that they may be abnormal in some way in their ability to relate to others and are deeply concerned about this or some other aspect of their functioning;
- (5) a minority who appear to be seriously disturbed and in need of psychiatric assessment.

In Grapevine's experience, the first three groups can be helped very effectively by the volunteers, supported as necessary by counsellors and field officers; there is, however, no hard and fast division between any of the categories.²⁶

The report recommended that the program continue.

37. The Council for Services to Youth in Adelaide has a similar approach to offering help to young people; it aims to deal with a very broad range of young peoples' problems. The director, Max Kau, emphasised the importance of working through a small voluntary organisation able to respond to changing needs without unnecessary bureaucracy.²⁷ We acknowledge the value of this approach and believe that such activities should receive official as well as voluntary support.

Contraception for young people

38. Human relationships programs should provide basic sex education as well as information about contraceptive methods and services. The overall aim of such education should be to develop responsible attitudes and behaviour, to help young people to understand and act on the basis that if pregnancy is not sought contraceptives should be used.

39. When it comes to specific contraceptive services for young people who are sexually active, some special factors have to be taken into account in advising on methods. For example, cost may be a barrier to young people without independent income. Other problems are the unwillingness of young girls to plan for sexual intercourse, and the unexpectedness of intercourse. For these reasons the pill, IUD or diaphragm may not be suitable. The pill is not always recommended for the very young girl whose pattern of menstruation has not been established. For similar reasons periodic abstinence methods may be unreliable.

40. The most effective methods may not be practicable outside steady relationships or for those whose sexual experience is intermittent or unplanned. For adolescents the need is for an immediate, low cost protection.

26. *Grapevine: Community sex education project*, Report on the experimental period ending 30 November 1974 (Grapevine, London, 1974), p. 41.

27. Evidence, pp. 1154–71, Mr Max Kau.

41. The best method for casual or intermittent relationships may well be the condom. This method is reasonably effective, available without prescription (though not widely enough) and is not expensive for occasional use. One of our submissions referred to a research program undertaken in North Carolina.²⁸ Free condoms were widely distributed to men under 20. In random surveys 69–81 per cent of boys said they had used a condom in their last sexual encounter whereas in only 15 per cent of cases were their partners using contraception. It was reported that the males were prepared to accept responsibility for contraception when given the opportunity. The fertility rate for the area dropped 19 per cent in the relevant period.

42. The need to provide ready access by young people to contraception adds weight to our view that condoms of appropriate standard should be widely available at reasonable cost. Young people should also be instructed how to use them effectively.

43. When condoms are not available, the less reliable method of withdrawal may have some value if properly practised. It does not require expense or preparation. In certain situations any method may be better than no method.

Age of consent

44. The age of consent to sexual relations is the age below which a girl's consent to sexual intercourse is not a defence to rape or (except in certain circumstances) to a charge of unlawful carnal knowledge.

45. The age of consent in Australia varies from 13 to 17 years:

| | |
|----------------------------------|----------|
| NSW (& ACT) ²⁹ | 16 years |
| Victoria ³⁰ | 16 years |
| South Australia ³¹ | 16 years |
| Tasmania ³² | 17 years |
| Queensland ³³ | 17 years |
| Western Australia ³⁴ | 16 years |
| Northern Territory ³⁵ | 13 years |

The problem is that if a doctor prescribes contraception for a girl under the age of consent, he or she could theoretically be charged with the felony of aiding or abetting carnal knowledge.³⁶ This view has been recently disputed by Professor D. Hamby, who said:

However, the essence of aiding and abetting is that one counsels, procures or assists an offender in the commission by him of the offence. It surely strains language to breaking point to suggest that the provision of contraceptives to the assumed victim of the offence, with a view to mitigating its consequences for her, can be regarded as encouraging or procuring the commission of the offence. From the point of view of the offender, the act of intercourse which is the essence of the offence is not facilitated. Furthermore, I should think that in cases of the kind where a doctor may contemplate prescribing contraceptives to such a patient, the patient would already be sexually active and the doctor would have formed a judgment that she would continue to run the risk of pregnancy if no prescription was given.³⁷

28. Submission 73, Jo Wainer, Fertility Control Clinic; C. B. Arnold & B. E. Cogswell, 'A condom distributing program for adolescents: the findings of a feasibility study', *American Journal of Public Health* 61, 4 (1971), pp. 749–50.

29. Section 71, NSW Crimes Act.

30. Section 48, Victorian Crimes Act.

31. Section 49, SA Criminal Law Consolidation Act.

32. Section 124, Tasmanian Criminal Code.

33. Section 215, Queensland Criminal Code.

34. Section 187, WA Criminal Code.

35. Section 65, NT Criminal Law Consolidation Act and Ordinance.

36. Submissions 73, Jo Wainer; 143, SA Medical Womens Society; Evidence, p. 808, Professor J. Leeton.

37. D. Hamby, Aspects of the law affecting the provision of family planning services to young people (ACT FPA Seminar, 8 August 1976).

H. A. Finlay maintains that a doctor could be liable only if advice was given in joint consultation to a girl under age and her boyfriend.³⁸ Despite these views the medical profession maintains a different opinion.³⁹

46. If there is any doubt about the matter it should be set right by providing that a doctor prescribing or supplying contraceptives in good faith and in the interests of his patient should not be subject to criminal proceedings of the kind mentioned.

Consent by minors to contraception

47. The Barson and Wood study of general practitioners found that only two of the nineteen doctors approached by unmarried minors would prescribe oral contraceptives without parental consent.⁴⁰ Negative attitudes by some doctors to prescribing contraceptives for minors were also found in some submissions. The reasons for the refusal by a doctor to prescribe for a minor may be legal, moral or ethical.

48. Under section 49 of the NSW Minors (Property and Contracts) Act, 1970, the consent of a minor over 14 is as effective in preventing a claim for assault and battery as if the young person was 21. In other States and Territories a girl can consent to treatment if she is considered sufficiently mature, i.e.

... capable of forming a sound and reasoned decision to undergo the treatment.⁴²

49. Our survey of hospital and clinic abortion facilities showed that clinics in both NSW and Victoria gave contraceptive advice and supplies to girls under 16 as seemed to be needed. Many young girls asking for contraceptive advice are already sexually experienced.⁴³

50. Most FPAs give advice and prescribe contraceptives for minors without requiring consent. In NSW this is done if the young person is sexually active. In the ACT the consent of the parent or person responsible is required. In Western Australia the FPA will not divulge information to the parent.⁴⁴

51. The same problem has arisen in other countries. More than twenty American states have provisions under which minors may receive contraceptive services without parental consent.⁴⁵

52. The Lane Committee considered the question as follows:

A doctor's first concern is with his patient's health and in this context he may decide that contraception is indicated. Under the Family Law Reform Act 1968 (which does not extend to Scotland) a minor of 16 years may consent to his or her own medical treatment. Most doctors, if asked for advice on contraception by a patient of under 16 years, would be likely to seek her permission to consult her parents, and, in our opinion, should always do so. If the girl refuses this permission, the doctor has three alternative courses open to him: he may break confidentiality with the girl in order to obtain her parents' consent to the treatment; he may refuse to continue with the treatment in the absence of consent by the parents, and so fail to give the girl the care which he may consider medically necessary and

38. H. A. Finlay, 'The impact of law on family planning in Australia,' *Journal of Family Law* 13 (1973-74), p. 753.

39. AMA, NSW branch, quoted in Hambly, p. 4.

40. Barson & Wood, 'A survey of the role of the general practitioner in family planning', *Medical Journal of Australia*, 20 May 1972, p. 1069.

41. e.g. Submission 535, Yvonne Foster.

42. O'Bryan, Sir Norman, quoted in Hambly, p. 3.

43. Evidence, p. 1120, Dr S. Siedlecky.

44. Commission survey of FPA facilities (see chapter 2 of this part).

45. Brian G. Fraser, 'The pediatric bill of rights', *South Texas Law Journal* 16, 3 (1975), p. 245; see also Twelfth Report of the Canadian Royal Commission on Family and Children's Law, *The medical consent of minors* (Vancouver, British Columbia, 1975).

leave her at risk of becoming pregnant; or he may continue with the treatment without parental consent.⁴⁶

53. Where the doctor was unable to obtain the girl's consent to consult her parents and was of the view that she would have sexual intercourse without contraceptives unless he provided them, the majority view of the Committee was that, in exceptional cases, doctors should make contraceptives available on the ground that this may be a lesser evil than allowing the girl to run the risk of pregnancy.⁴⁷

54. The problem of confidentiality has arisen in two recent cases. In a Canadian case a doctor was found guilty of misconduct for telling the parents of a 15-year-old girl that he had inserted an IUD. In an English case a health centre informed a 16-year-old girl's doctor about contraceptive services given to her. He told her parents and was later found not guilty of a disciplinary charge on the basis that the parents had an overriding interest in the welfare of the minor.⁴⁸

55. In our view it is important to clarify the law with regard to the provision of contraceptive services for minors, and the roles of the doctor, the patient and the parents of the minor.

56. The law should aim to ensure that decisions are taken in the interests of the young person and this may sometimes mean going against the wishes of the parents. The balance of interests may suggest that, if intercourse is to take place anyway, contraception should be provided. We do not agree that the provision of contraception will encourage sexual intercourse. Many young girls asking for contraception are already sexually experienced. Where the young person is 14 his or her interest will in many cases require that advice be given whether or not the parents consent. It is in principle desirable that they be involved and informed, but the doctor should not take it upon himself to do so, nor incur liability for failing to do so. In our view, 14 should be established as the age at which a minor may consent to medical treatment for contraceptive purposes other than sterilisation; for children below that age we agree with the majority view of the Lane Committee.

57. We stress that decisions of this kind place a heavy burden on the medical and other professions involved in fertility control services. Ideally counsellors should be available to advise young people and help them to understand and make fully informed and responsible decisions. Special youth services could fill this need.

Abortion

58. Many teenage pregnancies end in abortion. If our estimate is correct 18 000 pregnancies out of a total of about 44 000 each year to the under 20s end in abortion. A significant percentage of girls having abortions are under 16 (Preterm study 1974: 6 per cent; South Australia report for 1975: 3 per cent; our survey: 5 per cent). As mentioned, abortion is not necessarily more risky for teenagers than for others, nor is it more hazardous physically than continuing to term. There is, however, some evidence to suggest that abortion becomes more risky for this age group, because the young person may not recognise pregnancy, and may through fear, ignorance or lack of resources delay seeking advice. The *Medical Journal of Australia* recently carried this comment:

Particular attention does need to be given to the education of the adolescent girl, as she carries the greatest risk of the mid-trimester abortion—a risk which could be totally avoided with counselling and effective contraception in the first place, or by early abortion as a second best.⁴⁹

46. Lane report, vol. I, para. 243.

47. *ibid.*, para. 245.

48. *The Times*, 8 March 1971, p. 2.

49. 'Mid-trimester abortion and its consequences', *Medical Journal of Australia*, 22 January 1977, pp. 82–3.

59. Our hospital and clinic morbidity survey showed that of the whole sample of 2788 women 20 per cent were more than 10 weeks pregnant at the time of termination.⁵⁰ For girls under 16, 37 per cent were over 10 weeks including 16 per cent (twenty-one out of 128) over 14 weeks; 26 per cent of women between 16 and 19 were over 10 weeks pregnant. The results have not yet been fully analysed and therefore it cannot be concluded that these delays led to higher complication rates for this group. We would, however, support the view that teenagers need better access to information and advice and to counselling when an unwanted pregnancy occurs.

60. A recent study of teenage abortion points to the need for large-scale prospective studies of the long-term effects of abortion, and mentions that it is not clear whether there are adverse physical or psychological consequences of teenage abortion or whether these are any more serious than those of pregnancy and childbirth.⁵¹

61. It is particularly important that the young woman be given help in deciding which outcome to choose when an unwanted pregnancy occurs. Counselling both before and after abortion is necessary to assist her impartially to explore her own feelings and attitudes, to make a responsible decision and to discuss any feelings of guilt or loss which arise afterwards. There is also need for proper contraceptive advice to avoid a further unwanted pregnancy.

Consent to abortion

62. In NSW a girl of 14 can consent to medical treatment. In other States and Territories the consent of a minor may suffice if she is sufficiently mature. In cases of doubt the doctor may not be able either to proceed lawfully or ethically to approach the parents. The only alternative open is to encourage the girl to approach her parents.

63. Our survey revealed that clinics in NSW require parental consent if the girl is under 14. They will proceed on proof of age if the girl is 14, though parental consent is preferred. In Victoria parental consent or psychiatric referral is required for those under 16.

64. When consent is legally required and is not forthcoming there is no established procedure for authorising the operation. Even if the doctor proceeded, in accordance with an honest belief that the procedure was needed to avoid a risk to the mental or physical health of the patient greater than if the pregnancy were terminated, he might still incur civil liability. The current attitude of medical associations is such that many doctors would not perform an abortion on a minor without parental consent. The NSW branch of the AMA recommends doctors to consult the parents or guardian of minors under 16, even if the girl forbids it.⁵²

65. The task of the doctor has difficult legal and ethical aspects. Professor Hambly recently made these comments:

Doctors and other family planning counsellors who suffer from a sense of inhibition in providing their services should look for relief, not to the law, which plays a minor role, but to the policies of their professional organisations; perhaps these policies should acknowledge that no universally acceptable general rule can be prescribed for many of these moral issues, and that an attempt to impose one may be morally objectionable.

On a practical view, a doctor or other family planning counsellor who acts, with his patient's consent, according to his conscientious assessment of the patient's interests has nothing to fear from the law.⁵³

50. See Annexe IV.Q.

51. Judith Straton, Abortion and teenage pregnancy (University of Minnesota, December 1976, unpublished).

52. Australian Medical Association, NSW branch, Monthly Bulletin, 26 August 1974, p. 11.

53. Hambly, p. 13.

66. In America the right of minors to abortion, without parental consent, was argued before the Supreme Court as a matter of privacy, constitutionally protected. The Supreme Court, on 1 July 1976, declared unconstitutional state laws requiring the consent of parents of a minor to a first trimester abortion.⁵⁴

67. The question of abortion for young people raises difficult issues. The girl concerned has already had sexual intercourse. The issue is whether she should have the child or have an abortion. The younger the age, the less ready she is to take on the responsibilities of motherhood and the greater the concern and interest of the parents. Counselling is essential for the young girl. The doctor and the counsellor should encourage girls under 16 to involve their parents in discussions. We think that some young girls would welcome a sympathetic person speaking to the parents (who may be in ignorance of the situation) and explaining what is involved in the decision. The issue may arise less frequently than might be thought as our information is that the mother very often accompanies the girl or gives consent.

68. Ultimately, our view is that, provided she is capable of understanding and making a responsible decision and has had access to proper and thorough counselling, it is for the girl to decide whether to have the abortion or give birth to the child. Her decision should be freely made and an abortion should not be refused to a girl of any age merely because of the absence of parental consent. She should always be encouraged to involve her parents; where the doctor doubts her maturity of decision this is especially important. If she refuses to approach her parents, or if the parents refuse consent, the doctor acting in good faith and with due care in the interests of his patient should not incur criminal or civil liability.

69. It is difficult to put these views into legislative form, especially the need for counselling. This depends on the provision of services and on the availability of trained counsellors. The role of the law is not to enforce moral or ethical viewpoints, but to define rights and duties. We do not think the absence of parental consent should make unlawful an abortion performed on a girl over 14, provided that she consented to it. Nor should the doctor incur civil or criminal liability if the operation was performed in good faith in the interests of the patient. The law may need amending in some States to achieve this. Where the girl is under 14 and it is not practicable to obtain parental consent, the doctor should be free from liability if she is sufficiently mature to understand the issues and he forms the view in good faith that the operation is necessary in the interests of the girl.

54. *Family Planning Perspectives* 4, July–August 1976, p. 177; Fraser, p. 256.

6. Childbirth

1. Pregnancy and childbirth are important to the study of male and female relationships because they are a time when new family relationships are formed, and existing relationships are changed.

2. If women find the experience unpleasant, or if they feel a failure in any way, it can depress them and affect their relationship with the newborn child. Professor Carl Wood, Professor of Obstetrics and Gynaecology at Monash University, told us:

This poor experience may be handed down to the next generation.¹

3. Similarly, the *Medical Journal of Australia* has said in an editorial:

Conception and birth, traditionally times of celebration, are crisis periods when new behaviour patterns which will influence the family's welfare are formed. This fact should receive more attention, particularly by people interested in prevention-oriented health programs.²

4. We realise the significance of this area of inquiry but we were unable to undertake a detailed study of the subject. This chapter summarises the evidence presented to us and outlines the general conclusions that emerge.

Changes during pregnancy

5. A woman experiences pregnancy emotionally as well as physically as a result of the hormonal changes that are taking place in her body. Many people, including a woman's partner, are unaware of the intensity of feelings that a woman experiences during pregnancy. A strain may be put on the relationship between a man and a woman during pregnancy because of the anxiety and depression that the woman may be experiencing, and because of the changes in sexual relations which occur during pregnancy.³ The Victorian branch of the Childbirth Education Association wrote that understanding the changes that are involved in man-woman relationships would help to ease this strain.⁴

6. Professor Beverley Raphael, Associate Professor of Psychiatry at the University of Sydney, has observed:

Sexuality is likely to change considerably during pregnancy, and should be a legitimate area of history taking and assessment. Some women show a heightened sexual desire and arousal, perhaps related to pelvic congestion or the enhanced sense of well-being which accompanies many pregnancies, while others respond to pregnancy as an 'illness', or to physiological alterations with lowered arousal.⁵

7. A number of submissions said that programs of sex education which discuss pregnancy and childbirth should include discussion of the emotions and changes connected with these events.⁶ This should also be an integral part of pre-natal care:

1. Evidence, p. 553, Prof. Carl Wood.

2. 'Are fathers really necessary?', *Medical Journal of Australia* 1 (1973), p. 920.

3. Richards, Commission research report, no. 14.

4. Submission 998, Childbirth Education Association (Victorian branch).

5. B. Raphael, Primary care and the prevention of psychiatric disorder: family planning, ante-natal care and childbirth, *Australian Family Physician* 5, 8 (1976), p. 1092.

6. Submissions 10, Mrs Anne Hapke; 126, Nursing Mothers Association of Australia; 586, Catholic Womens League (NSW); 998, Childbirth Education Association (Victorian branch).

The emotional changes that are so much a part of pregnancy may need to be discussed. The emotional lability of the pregnant woman, with rapid swings of mood, periods of apparently irrational anger, weeping or elation may seriously disrupt relationships if her sensitivity is not understood. The expectant father may respond to the changes in his wife, or to his own developmental crisis, by his own changes of emotional response.⁷

8. Some organisations criticised aspects of pre-natal care.⁸ Parents Centres (Australia) wrote:

Whilst we do not hesitate to commend the very real total physical care, we are appalled at the emotional care offered by many doctors, nurses and pre-natal classes.⁹

It was said that, allowing for notable exceptions, the majority of doctors are too busy to allow any questions to be asked:

Some mothers actually fear they will not have time to dress before being shown out of surgery. The doctors stand at the door, giving the mother no time to ask questions. Others are extremely paternalistic. 'Don't worry about that—leave it all to me, my dear' being the usual answer to any and all questions.¹⁰

9. Migrant women are particularly isolated from information and advice. Usually they do not have their own mothers in Australia, and there is no literature in their own language. Nanice Leggas, a Melbourne librarian, said that child care booklets and pregnancy information literature should be translated into all the major languages. A great deal could be done with audio-visual material.

When these mothers go to pre-natal sessions to do their exercises for childbirth, surely they could show a few films on having babies and post-natal care.¹¹

10. Australian research has shown that women who exhibit a high level of anxiety early in pregnancy are more likely to have complicated deliveries. A study by Professor Pilowsky, Professor of Psychiatry at the University of Adelaide, of eighty-two married women attending two Sydney hospitals for their first child revealed that women having childbirth complications were those who earlier in pregnancy had demonstrated a negative attitude to the pregnancy; expressed concern for the condition of the child; saw their employment as being disrupted; described a great number of contacts with women who had had complicated pregnancies; and described their mothers' health as poor. In addition, they tended to complain of greater numbers of physical complaints, were anxious and tense.

Clearly if a woman is anxious, uncertain about pregnancy and this is going to lead to complications and she is going to have a child which is not perhaps particularly well as a result of the complications and she is not going to be at her best herself, the stage is set for the development of a bond which may not be the best kind of bond you would want. That is the beginning, the very beginning of a very important human relationship, so if we could do things about picking up these difficulties (and I am not talking about psychiatrists doing this now . . . [but] obstetricians . . . and social workers) we could avoid a lot of problems later on.¹²

11. At present, in busy ante-natal clinics, it is not easy for anyone to sit down with an expectant mother and find out how she is, what her problems are, what she has to do at home, whether she is working, how she feels about her pregnancy, what are her fears and fantasies, what plans she has made.

7. Raphael, p. 1095.

8. Submissions 560, Parents Centres (Australia); 1073, National Right to Life Association.

9. Submission 560, Parents Centres (Australia)

10. *ibid.*

11. Evidence, p. 2807, N. Leggas.

12. Evidence, p. 1179, Prof. I. Pilowski.

I am really not sure about the degree of privacy they can get even for the short period that they spend with the obstetrician—I do not know enough about that but from what I have seen around the world I imagine there is not much.¹³

12. Many pre-natal clinics were built some years ago; buildings have become too small for the numbers of people using them, and hospitals are still being designed with no account for privacy.

13. Many couples experience mixed feelings about a pregnancy, even if it has been consciously planned and wanted. Not all women experience pregnancy as a happy occasion. It has been suggested that when this natural doubt is denied or repressed, it is likely to influence the course of pregnancy perhaps by predisposing to medical complications or, later, in its interference with the parent-child relationship.

Mothers whose ambivalence is not acknowledged may over-protect the baby when it does arrive, or may react harshly, punishing its most minute observable 'badness', even to the extent of battering.¹⁴

Pre-natal education

14. Some submissions expressed the view that pre-natal classes should be more widely available, should include fathers, and should incorporate child rearing and the emotional adjustments that need to be made by parents during pregnancy and afterwards.¹⁵ We were informed that most classes are large (over twenty-five mothers) and that the course content tends to be purely physical with little or no attempt being made to present an insight into normal emotional reactions to pregnancy, labour, or the first year of parenthood.¹⁶

15. A mother of four children wrote:

I would like to see available . . . especially during one's first pregnancy, information about actual childbirth, how to handle and care for a new baby, the psychological and physical effects on the mother and father, breast-feeding etc. A little more knowledge like this could have made this time a much happier and more relaxed period for me, my husband and our baby.¹⁷

16. Pre-natal education should also provide assurance for women who are experiencing fears about the onset of labour, the provision of pain relief, fears of losing control by crying out during childbirth. Pre-natal education should help a woman to face and discuss these fears, especially during the later stages of pregnancy.¹⁸

17. Pre-natal classes run by the Royal North Shore Hospital in Sydney are one good example of comprehensive classes in that, as well as covering childbirth and parenthood, there is also discussion on marital relationships, sexuality, family planning and contraception. Paediatrician Dr Clair Isbister said she would like to see more funds available for preparation for parenthood programs in the maternity hospitals.¹⁹

18. Dr Michael Harris, a paediatrician at the Royal Hospital for Women, said that in his belief the majority of women go into pregnancy with fear. Today's smaller families mean that their contact with children before their own maternity is limited. He would like to see pre- and post-natal classes available to all mothers in obstetric hospitals throughout Australia. At the Royal there is a program for women attending

13. *ibid.*, p. 1182.

14. Raphael, p. 1092.

15. Submissions 560, Parents Centres (Australia); 568, Catholic Womens League NSW.

16. Submission 560, Parents Centres (Australia).

17. Submission 940, Mrs J. Sheridan.

18. Raphael, p. 1095.

19. Evidence, p. 3052, Dr Clair Isbister.

hospitals throughout Australia. At the Royal, there is a program for women attending the obstetrics outpatients which is both educational and therapeutic, but has a different approach to programs for intermediate patients.

As an example, the girl who goes through the obstetrics outpatients very often does not know why she is having blood tests, whereas the intermediate girl probably has the background to know why, so the girl who comes through the public outpatients department has to know what the blood tests are, what it means, why it is being done. This is part of the therapy in that it allays anxiety but also it is a means by which a girl can relate to a hospital, an institution, and can lead on to more important facets of education.²⁰

19. In most cases funds for pre-natal classes are raised voluntarily. Lecturers also give their time voluntarily. Even when grants are made available there may be difficulties.

I am concerned that the program in Miranda hospital has found it extremely difficult to get any funds. We have been doing it for 25 years and are constantly after money. We only got a grant this year. We got it at the end of December and we were told it had to be used by the end of June so that 5 months of our time had already gone and it was not very much anyway.²¹

Dr Isbister said she would like pre-natal classes and preparation for parenthood classes to be offered as an integral part of hospital service. At present requests for funds are often met by the response that hospitals care for the sick.

I think hospitals should be involved in preventing illness as well and it should all come under general hospital administration.²²

Preparation for childbirth

20. Childbirth is an area where lack of knowledge and fear work against an easy delivery, yet the subject is not discussed openly. To overcome this ignorance, pupils in high schools should be given education in pregnancy and childbirth, including the various stages of labour and delivery techniques.²³

21. It was suggested to us by Parents Centres (Australia) that mothers need to be trained in the psychological way of dealing with childbirth so that they are best able to experience birth as a 'peak emotional experience'.²⁴ However, evidence shows that not all women experience birth in this manner, and these differences should be explained and discussed. For example:

The psychological experience of childbirth may be a critical highlight in the woman's life. Some experience it orgasmically and joyfully; others as a pleasure-pain yet integrating experience; others as a non-event, because of heavy sedation or anaesthesia; and still others as a traumatic, destructive and mutilating experience. Ante-natal preparation, knowledge of likely events and, of course, freedom from excess anxiety will all be helpful.²⁵

22. An English study by Dana Breen on women's feelings about their first pregnancy also found this variety of feelings about childbirth. She classified responses about the birth experience as either positive or negative:

Slightly more than half of the responses which I could classify in this way referred to a positive experience . . . Negative experiences often related to childbirth . . . Sometimes fear, anxiety about coping with the newborn or morning sickness during pregnancy were mentioned. Positive experiences were only slightly more often expressed by women in the well- and medium-adjusted groups.²⁶

20. Evidence, pp. 148-9, Dr M. Harris.

21. Evidence, p. 3046, Dr Clair Isbister.

22. *ibid.*, p. 3052.

23. Submission 371, Anne Armstrong.

24. Submission 560, Parents Centres (Australia).

25. Raphael, p. 1105.

26. D. Breen, *The birth of a first child: towards an understanding of femininity* (Tavistock, London, 1975), p. 180.

23. Dr Clair Isbister reported that experience has shown that pre-natal education and training may reduce the amount of anaesthesia needed during childbirth, shorten labour, produce a more relaxed childbirth, and reduce the need for forceps and episiotomies.²⁷

24. Women who receive physical and mental training for childbirth, as well as needing less medication, may also more often experience a rewarding sense of exhilaration in childbirth.²⁸

Induction of labour

25. Some organisations and individuals expressed concern about the increasing trend towards induction of labour for the sake of professional rather than parental convenience.

26. Opinion seems to be divided on the question of induction of labour. One view is that induction need not be more distressing than spontaneous labour provided it is properly done. Inducing labour so that the birth occurs in the daytime ensures a wide-awake staff, full back-up facilities and a rested mother.

27. Another view is that inductions reduce the quality of the birth experience for some women, and should not be performed unless there is a medical necessity.²⁹

I think it is positively wicked that so many women are 'persuaded' (often left unaware that they have any choice in the matter or are misled or kept ignorant about what it really entails) to have their babies' births induced purely for the convenience of the obstetrician.³⁰

28. Professor Carl Wood said that some women and some doctors do find it more convenient to plan a delivery by induced labour, but a woman should not be persuaded to have an induction unless medically necessary. There are some statistics to show that where induction of labour is skilfully done, pre-natal mortality rates have dropped, so that in many cases where labour is induced (except as a matter of convenience) the birth may be safer.³¹

29. An article that appeared in the *Sydney Morning Herald* discussed varying opinions on induction. The records of newborn babies treated for respiratory distress at King George V Hospital were analysed and a relationship was found between elective induction and respiratory distress in newborn babies. On the other hand, a survey at the Royal North Shore Hospital found no such relationship.

The lesson to be learnt is that elective induction should be performed only when the doctor is quite certain the baby is mature. This effectively means that it should be confined to those hospitals with facilities for estimating foetal maturity.³²

In those cases of respiratory distress which were investigated neither ultrasound picturing nor womb tapping to determine maturity was performed.

30. We have not investigated the current practice with regard to induction of labour and cannot comment on the allegations which have been made. Inducing labour for medical reasons, such as diabetes or a prolonged pregnancy, is not challenged. Public debate on the issue³³, and submissions to us, have shown that some women hold very strong views on whether or not labour should be induced.

27. Evidence, p. 2419, Dr Clair Isbister.

28. Submission 999, Childbirth Education Association (NSW branch).

29. Submissions 126, Nursing Mothers Association; 422, Margaret Coombs; 560, Parents Centres (Australia); 999, Childbirth Education Association (NSW branch).

30. Submission 422, Margaret Coombs.

31. Evidence, pp. 557-8, Prof. Carl Wood.

32. 'Baby problems link with birth induction', *Sydney Morning Herald*, 25 May 1976.

33. An example of public debate appeared in a number of letters published by the *National Times* and showed the strength and variety of opinion: 'Childbirth in hospital—a human event', *National Times*, 16-21 December 1974, pp. 30-3.

31. The woman should be consulted and kept fully informed of the reasons for induction and should have a choice except in case of necessity.

The use of medication

32. Research has shown that anaesthetics and analgesics alter the normal foetal environment:

Even small doses of depressant drugs will affect infant behaviour in the early neonatal period.³⁴

According to Constance Bean's *Methods of childbirth*, a 1968 study by Dr T. Brazelton showed 24-hour delays in a baby's weight gain, delayed sucking response, and abnormalities in electroencephalograms during the early days after birth associated with babies in medicated births as compared with babies whose mothers had not received medication.³⁵

Again this is an area where people hold strong and divergent opinions. Some submissions said that the administration of analgesics and anaesthesia may deprive women of feelings of achievement in childbirth.³⁶ Others believe that being relieved of pain will enable a woman to enjoy the birth experience more.

33. The most important issue here is that a woman should be given the choice of whether or not she is to receive medication. The Nursing Mothers Association of Australia and others believe that mothers should be advised of the effects that obstetrical medication may have on their babies.³⁷

Informed consent of the patient is necessary and each step of the procedure should be explained immediately before it is carried out.³⁸

34. Overall, the risks of pain control techniques should be weighed up against the benefits they provide:

The wishes of those patients who consider pain in labour to be imaginary, beneficial or even essential must of course be respected. However, the majority require some analgesia, and a few need complete analgesia. In spite of this, and the inadequacies and complications of narcotics and general anaesthetics, obstetric epidural analgesia has made slow progress in this country . . . It is essential that all who practise obstetrics be familiar with the techniques and their clinical application, so that epidural analgesia can be instituted at least in those cases where its benefit exceeds the analgesic effect.³⁹

Hospital and medical procedures

35. Professor Carl Wood said that there appears to be a lack of collaboration between childbirth educators, physiotherapists and medical and nursing staff, so that something that a woman is taught in pre-natal classes may be quite different to what happens during childbirth.

I am an adviser to the Childbirth Education Association. I assure you from looking at their reports, that they make on what happens to their patients entering hospital during childbirth, there is a discrepancy from what the patient expects and what happens. I am not trying to say who is right. If they were all agreeing to do the same thing the patient would be a

34. F. Bencina, 'Local anaesthesia for delivery', *Australian Family Physician* 4, (1975), p. 352.

35. Melissa Sones, 'Giving birth', *Ramparts Magazine* (1974), p. 51.

36. Submissions 422, Margaret Coombs; C573, confidential; 999, Childbirth Education Association (NSW branch).

37. Submissions 126, Nursing Mothers Association; 560, Parents Centres (Australia); Evidence p. 2480, M. Brown and L. Sullivan.

38. Bencina, p. 340.

39. *ibid.*, p. 361.

lot better off. There is nothing more disturbing to a patient than not knowing what is happening or in fact having something happening which you do not expect or do not wish. It is like if you have been ill in a foreign country; you might have excellent people looking after you but you are sure they are doing the wrong thing because you cannot understand them.⁴⁰

36. Some submissions said that hospital procedures are planned around hospital routine rather than the needs of the mother, father and baby. It was sometimes felt that doctors and nurses did not pay enough attention to the feelings of the mother or the father during childbirth.⁴¹

The mother is regarded as a body to be manipulated through a series of procedures, and to conform to hospital routines and efficiency. Her partner is often merely tolerated and regarded as unimportant at this time.⁴²

37. The Royal Hospital for Women in Sydney conducted a survey and found that one of the major complaints by women was staff attitudes and ward routines:

There is also the traditional authoritarian atmosphere of a hospital, with its medical and nursing hierarchies, that intrudes into many areas. The impression often lingers that the hospital is run for the relief and satisfaction of staff, rather than patients.⁴³

38. The labour ward environment and atmosphere is seen as being very important to the childbirth experience. Professor Raphael writes:

Although supportive caring is usually the norm, there are certainly times when hostility to particular patients, authoritarianism, and derogatory and infantilising comments become the pattern of response. When a woman's behaviour does not fit in with staff members' values as to appropriate intra-partum response, she may be unconsciously rejected and openly criticised.⁴⁴

39. Marion Brown and Lucy Sullivan from Parents Centres said, at our Sydney hearings, that the patient is often not consulted about treatment, either in labour or with regard to her infant. It is considered that the staff know better and hence what she does and her own values are of no importance at all.⁴⁵ The way the mother is treated by hospital procedures during childbirth may have important effects on her well-being.

. . . medical ideology can do a lot to prevent childbearing being reduced . . . from an immense creative joy to a boring mechanical function and thus prevent the impoverishment of many lives.⁴⁶

There is gathering evidence that the traditional lithotomy position for childbirth (back flat, legs in stirrups) obstructs the normal process of spontaneous birth by decreasing the intensity of the contractions, inhibiting the mother's efforts to push the baby out, and increasing the need for forceps and episiotomy. Mothers who are supported to a semi-sitting position may have an easier birth.⁴⁷ The Nursing Mothers Association wrote to us that the normal physiological process of childbirth is also being disturbed by the routine use of forceps and episiotomy in cases where they are not really necessary.⁴⁸

40. Evidence, pp. 553-4, Prof. Carl Wood.

41. Submissions 118, Childbirth Education Association (Qld branch); 126, Nursing Mothers Association; 998, Childbirth Education Association (Victorian branch).

42. Submission 998, Childbirth Education Association (Victorian branch).

43. *National Times*, 16-21 December 1974, p. 30.

44. Raphael, p. 1105.

45. Evidence, pp. 2481-2, M. Brown, L. Sullivan.

46. Submission 422, Margaret Coombs.

47. Submissions C513, confidential; 560, Parents Centres (Australia).

48. Submission 126, Nursing Mothers Association.

The father

40. The role of the father is seen as being very important. The father should be encouraged and trained to take an active role during his partner's pregnancy and during the birth of his child. Some submissions stated that the father should always be allowed to be present during labour and delivery, whether or not the couple are married, to provide the emotional support that the mother needs.⁴⁹

The shared intimacy of having a baby together adds a new meaning to their union and both parents can establish close emotional bonds with their child right from the beginning.⁵⁰

41. A father who was recently allowed to be the first father to attend the birth of his child at a Sydney hospital wrote:

This unique experience in our life cycle, this natural act, should not be hidden behind medical taboos but should be open to the father to share.⁵¹

Some labour ward staff actively encourage the father to attend. Some state that the husband may attend, but, in practice, this is made difficult. Some mothers find it necessary to sit at the lifts in vestibles to be with their husbands. Research indicates that fear adversely affects uterine mobility and blood flow, and yet many mothers are, as a result of hospital routine, subjected to separation from husband, family and friends at this time of emotional crisis. Some hospitals will not allow the baby's biological father to attend, even though the mother wishes. No relatives or friends are allowed in place of the husband. This is discrimination against those mothers whose husband is overseas, or unable to attend, and mothers who are not married.⁵²

42. A number of fathers expressed the opinion that they felt it important to be with their partner during childbirth. One father said:

This, I feel, would help give a very sound base for the start of relationships within the family unit.⁵³

43. The usefulness of being present at birth in preparing a man for his role as father has been commented on elsewhere:

There are no physiological and hormonal changes which prepare him for the father role. The experiences which are particularly salient in orientating the father towards his infant are yet to be documented, but it could be that emotional involvement in pregnancy, in labour and childbirth are indeed useful acculturation processes.⁵⁴

44. The Nursing Mothers Association believes that, as well as being present during childbirth, the father should be allowed to hold his baby immediately after birth and during hospitalisation so that the baby is not a stranger to him when it goes home.⁵⁵

The non-admittance, or admittance under sufferance, of the father, the non-allowance to put the babe to breast on delivery, the separation immediately of the babe from the mother, the father from the mother and baby, leads to three strangers coming together on discharge from the hospital—three strangers with little confidence, exceedingly vulnerable to all the stresses of the post-partum period.⁵⁶

49. Submissions 118, Childbirth Education Association (Qld branch); C513, confidential; 560, Parents Centres (Australia).

50. Submission 998, Childbirth Education Association (Victorian branch).

51. Submission 190, J. D. Lewis.

52. Submission 560, Parents Centres (Australia).

53. Submission 190, J. D. Lewis.

54. J. E. S. Alwyn, 'Social aspects of pregnancy—Canberra survey', *Medical Journal of Australia* 2 (1975), p. 344.

55. Submission 126, Nursing Mothers Association.

56. Submission 560, Parents Centres (Australia).

45. This problem of lack of contact between a father, his baby and his wife was discussed in an editorial in the *Medical Journal of Australia*:

The father's exclusion . . . is seen in many obstetric hospitals. Enthusiastic but untutored, he can be easily demoralised by staff attitudes and labour floor procedures. After the delivery he will be fortunate if he cuddles his child before it is whisked away to a sterile sanctuary where, at specified times, he will later be allowed to view it from a distance filled by jostling strangers and through a plate-glass barrier. He should savour any moments alone with his wife. Visiting out of hours is discouraged in the wards, so new parents must share each other with relatives and friends.⁵⁷

46. Dr Hugh Jolly told us he believed that fathers are neglected in training for their role. He said that the father-to-be should be trained for his role in the delivery room, which includes placing his hands on the mother's abdomen so that he can understand, experientially, the birth process. He believes that the father should be the one to take the newborn infant and place it in the mother's arms.⁵⁸

47. Parents Centres observed that although husband and wife may choose a particular doctor because they want to be together at the delivery, there is always doubt as to what will happen on the day. During each visit the mother is told:

Perhaps it will be possible, depending on whether all is normal and the sisters allow your husband to stay.⁵⁹

Should the delivery present problems, however, or the baby be stillborn or deformed, it is still better for the husband to be present in order that the parents may comfort each other.

This is, after all, a family unit, who together will face many crises and who must resolve them together.⁶⁰

Breast-feeding

48. The Commission received a number of submissions on breast-feeding, including one from the Nursing Mothers Association of Australia⁶¹, a voluntary lay organisation with a membership of some 13 500 in every State and Territory. In the year 1974 the Association received over 56 000 requests for counselling and information on the subject of breast-feeding; the Association is also concerned with other issues related to childbirth.

49. We were told by the Nursing Mothers Association that Australia is probably the only country in the world where there is an increase in the breast-feeding of babies. Criticisms were made of hospital procedures, however. A common practice in Australia is to delay the time of the first breast-feed, and this is not in the best interests of either the mother or her newborn infant. Contact between mothers and babies is then restricted to feed times. These feed times are set according to a 3 or 4 hourly routine, and are of a set duration such as 15 or 20 minutes. There is no night feeding, and sometimes the babies are given supplemental bottle feeding.⁶²

50. This situation is regarded as being unsatisfactory because it distresses some mothers and babies and contributes to failures in breast-feeding.

57. 'Are fathers really necessary?', *Medical Journal of Australia* 1 (1973), p. 920.

58. Commission consultation, file S147.

59. Submission 560, Parents Centres (Australia).

60. *ibid.*

61. Submission 126, Nursing Mothers Association.

62. Submissions 126, Nursing Mothers Association; 560, Parents Centres (Australia); C1009, confidential.

I couldn't breast-feed my baby. On the fifth day they told me I had no milk and the baby would have to go on the bottle.

is a frequent statement from Australian mothers.⁶³

51. Mothers were made anxious by the fact that the time was too short for proper feeding or any other sort of contact. In some cases babies were not interested in breast-feeding because of the supplemental feeds they had been given. The build-up of milk in the breasts during the nights without feeding makes some women feel very uncomfortable.⁶⁴ Yet night feeds are sometimes not allowed on the grounds that other patients would be disturbed. Sometimes sedatives and/or analgesics are given and these pass through the mammary tissue to the newborn. The Nursing Mothers Association recommends studies into the effects upon the newborn of drugs dispensed to the nursing mother.⁶⁵

52. The Commission considers that mothers should have greater freedom in this matter and that strict rules should be relaxed. While we agree that breast-feeding should be encouraged, there should, however, never be any attempt to make mothers who cannot breast-feed, or do not want to breast-feed, feel inferior in any way.

Parent-child bonds

53. . . . man's first human relationship is concerned with his mother in the womb and continues and grows after birth.⁶⁶

Margaret Fowler from the Nursing Mothers Association said that the baby responds to the mother not after the first 6 months, as is frequently suggested, but in the first few hours.

If it is in the mother's sight and the mother's company, this starts a response from the mother in her maternal attitude towards the baby; this can grow and develop as the baby develops the capability of responding to the mother. It is in fact the first interpersonal relationship of the whole of its life.

Studies are showing that the baby's capabilities of recognition, of hearing, of smelling are quite profound even in the first days after birth. The more a mother knows about this sort of thing the more aware she is of it and the more concerned . . . therefore she wants her baby to be with her.⁶⁷

54. Professor Beverley Raphael similarly stresses the importance of the neonatal period for the establishment of effective mother-child bonds:

The earliest mother-infant contacts will be very important in the development of her attachment bonds with the baby, and in the growth of her maternal responsiveness. Many mothers who experience a lapse of several days before they are able to hold their babies describe the extra strangeness and awkwardness they feel . . . Where the requirements of medical care make such separation essential, every effort should be made to facilitate the woman's involvement with the baby.⁶⁸

55. Some people consider that the first 3 days after birth are so important for the formation of these bonds that other considerations, such as hospital routine, should be put aside to allow maximum contact between mother and child.⁶⁹

. . . an experiment in nature, in which mother and child had to be separated during the neonatal period, suggested that the incidence of child abuse, 'failure to thrive' and abandonment in these non-contact situations was significantly higher than in control groups

63. Submission 126, Nursing Mothers Association.

64. Submissions 126, Nursing Mothers Association; C513, confidential; 560, Parents Centres (Australia); C1009, confidential.

65. Submission 126, Nursing Mothers Association

66. Evidence, p. 699, Margaret Fowler.

67. *ibid.*, pp. 699-700.

68. Raphael, p. 1106.

69. Evidence, p. 1972, J. Redding and J. Salom; p. 2968, A. Samuel.

where mother and child were allowed early and undisturbed communion . . . The mother and child must be available to each other during this critical period, and the development of the bonding process can be damaged by intrapersonal difficulties in either partner, as well as interpersonal barriers (such as plate-glass windows, intrusive grandmothers, obstructive medical personnel, books with poorly conceived and articulated concepts and poorly tested edicts on how to mother etc.) that interfere with the bonding process.⁷⁰

56. Perhaps the ideal solution to this problem is the provision of rooming-in facilities. In this way the mother can have unlimited access to her baby during the day, while the baby can be returned to the nursery at night so that the mother can obtain the sleep that she needs.

In Australia most hospitals have wards or private rooms with central nurseries, the babies being brought to the mothers for feeding 4-hourly. They are expected back in the nursery within 45 minutes. This does not recognise the innate needs of the baby nor of the mother. When mother and child leave hospital they leave as strangers and weeks are spent in establishing a bond. Further, the child and father are separated. The father may see his child through glass but he may not touch. It is truly amazing that any father becomes involved in the care of his infant when mother and child return from hospital. At present the functioning of routine 4-hourly feeds and separation of child and mother is to the detriment of the long-term relationships of those involved.⁷¹

Rooming-in facilities should be provided for those mothers who want them so that parents can have access to their babies, and feeding does not need to be carried out to a strict routine.⁷² Rooming-in should of course be a matter of choice for the mother.

57. Professor Carl Wood said that:

. . . a number of hospitals try to offer a variety of access by the mother to the baby. Some mothers want to have the baby all the time, feed the baby when it wants to be fed, and would like the baby sleeping with them. There are other mothers who would like a more rigid regime where the baby is not with them and they do not hear it crying all the time . . . There is a move for hospitals to be more flexible in this respect.

This flexibility has a price in terms of crying babies disturbing other women who then complain, or of nurses or midwives who object.⁷³

58. Another alternative which has been suggested is the maternity home:

The maternity home is an alternative to the strict choice between home versus hospital birth . . . Combining both the friendly, warm atmosphere of the home with the safety and expertise of the hospital (plus maximum control by the mother of her birth experience), the maternity home could be set up as a community health centre offering information and services for every phase of the pregnancy, from pre-natal care, nutritional and family counselling through delivery and extensive post-partum follow-up. Run by and for women, with midwives providing the bulk of the care, the birth centre would charge on a low sliding scale.⁷⁴

This type of maternity home must have access to intensive care or emergency back-up facilities.⁷⁵

59. Premature babies and their mothers are completely separated for long periods; the mother frequently returns to her old way of life as if the baby had not been born. It

70. H. P. Coppolillo, 'Drug impediments to mothering behaviour', *Addictive Diseases* 2, 1 (1975), p. 205.

71. Submission 560, Parents Centres (Australia).

72. Submissions 118, Childbirth Education Association (Qld branch); 126, Nursing Mothers Association; 560, Parents Centres (Australia); 998, Childbirth Education Association (Victorian branch).

73. Evidence, pp. 555-7, Prof. Carl Wood.

74. E. Fishel, 'Childbirth: a feminist view', *Ramparts Magazine*, (1974), p. 44.

75. Also suggested in Evidence, p. 2480, M. Brown and L. Sullivan.

has been found that babies separated in this way are more likely to be battered⁷⁶ and general family relationships are more likely to break down. Mothers report that it can take up to a year for feelings of warmth toward the baby to develop. Yet they are rarely given the opportunity to discuss this. Mothers could be trained to do some of the things which the nurse now does for the premature baby, and this would establish contact. This could result in some extra demands on hospital routine, but even for medical reasons such an approach is justified; indeed it is highly desirable.⁷⁷

60. The present common Australian practice of excluding other young children from visiting their mother and newborn infant in hospital is an emotional hardship on the whole family. Difficult sibling behaviour, when the mother returns home with the newborn, is often caused by sibling jealousy of the newborn rather than by anxiety over separation from the mother. The child's exclusion has made it harder to feel involved in the event and enthusiastic about the new baby.⁷⁸

61. Maternity care should be family centred:

This permits the mother to have the baby with her during the day. During visiting hours the baby may be returned to a central nursery. The father may visit between 8 a.m. and 9 p.m. and he may hold, bathe, change his child. During the evening special talks could be given to all parents on such topics as childhood growth, emotional development, illnesses etc. A particularly valuable learning period is at present not being taken advantage of here. Even babies in humidicribs do better when fondled and who better to do this than their parents. There is no difficulty in teaching the parents the correct techniques in intensive care. Some hospitals are already permitting this . . . it should be Australia-wide.⁷⁹

Home births

62. We heard that many women are unhappy with the hospital situation where medication, induction and forceps are often used as a matter of routine. Some of these women are electing to have their babies at home with the help of a midwife⁸⁰ and the view was expressed that women should be given this option.

63. Professor Carl Wood said this growing desire was just one aspect of issues related to women and health. It was an important example because it showed that while hospitals may provide the optimum physical environment they do not provide the best emotional environment. In England, where home deliveries are more common:

. . . the emotional side of the situation there is optimal . . . if the home is a happy home or reasonably happy . . . The husband is out the back having a cup of tea; the midwife is having a chat and the kids are out the back. Everyone is excited. It is an important event. The children learn about reproduction; the relationship between the mother, baby, brothers and sisters is established. They are all in it. It is an important event in the family.⁸¹

64. The risk of infection in babies is believed to be lower in the home environment where the baby is isolated from other babies who may have infections. The Netherlands, as an example, has one of the lowest infant mortality rates and a very high level of home confinements.⁸²

76. L. Castle & A. M. Kerr, *A study of suspected child abuse*, (NSPCC, London, 1972); E. Elmer & G. S. Gregg, 'Developmental characteristics of abused children' *Pediatrics* 34 (1964); A. E. Skinner & R. L. Castle, *78 battered children: a retrospective study* (NSPCC, London, 1969).

77. Submission 560, Parents Centres (Aust.).

78. *ibid.*

79. *ibid.*

80. Submission 229, M. J. Ligtermoet.

81. Evidence, p. 554, Prof. Carl Wood.

82. Evidence, pp. 1960-8, H. Ligtermoet; p. 2480, M. Brown and L. Sullivan.

65. Home delivery requires the provision of midwifery services and back-up services such as ambulance and blood transfusion. Often pre-natal screening will discover cases where a home birth would be too risky. Such risky cases would include diabetes, severe anaemia or histories of prematurity, prolonged or difficult labour, foetal losses, multiple births or unusual position of the foetus. Professor Wood commented:

I cannot agree that the home delivery is the optimum from the physical point of view. There are certain unusual complications which occur where a baby would die at home and would not die at hospital. I think it would be important for people who wish to switch all deliveries to the home to consider these two aspects of the subject. Obviously you have the ideal situation in the hospital for physical complications and an ideal situation emotionally at home (or you could have). I think a compromise is probably best. My compromise is the delivery should occur in a hospital firstly and secondly hospitals could be made more humanitarian . . . I think patients would fix it up very quickly like our students do . . . After that they could be discharged earlier to their homes, within one or two days depending on the type of delivery. They could have a nurse visiting them at home or domestic help if necessary to cope.⁸³

66. Parents Centres also believed the best approach was to make hospitals more homely. Women should still have the choice, however, regarding home deliveries, but should be advised of the medical reasons why hospital deliveries are usually considered preferable.⁸⁴

Post-natal care

67. Mothers continue to need support and information after the birth of their child. Many of the voluntary organisations such as Nursing Mothers and Parents Centres have members who visit hospitals to talk to new mothers and to invite them to meetings when they return home.

68. Margaret Mead, in conversation with us, talked about a developing scheme in the United States whereby 'competent' mothers in maternity hospitals are encouraged to support and counsel inexperienced mothers. Their advice is often more heeded than advice from professionals.

69. The immediate post-natal time is the only occasion when women really provide a captive audience. Group discussions within maternity hospitals after the birth of a child should be encouraged. Dr Michael Harris believes there is a strong case for hospital programs to assist parents immediately after the birth of their child in establishing firm relationships.⁸⁵

Post-partum depression

70. A large number of mothers appear to suffer post-natal depression. Severe depression amounting to psychosis generally occurs in one out of 500 births⁸⁶, while 70 to 80 per cent of women are believed to have mild depression, or 'the blues'.⁸⁷ As many as one in four women are thought to experience more or less incapacitating neurotic or depressive symptoms. In extreme cases women generally seek treatment, but a large number who seem unable to cope try to struggle on without help. Parents

83. Evidence, pp. 555-6, Prof. Carl Wood.

84. Evidence, p. 248, M. Brown & L. Sullivan.

85. Evidence, pp. 148-59, Dr M. J. Harris.

86. Submission 560, Parents Centres (Aust.)

87. Lennart Kay & Ake Nilsson, 'Emotional and psychotic illness following childbirth', in John G. Howells (ed.) *Modern perspectives in psycho-obstetrics* (Churchill Livingstone, Edinburgh, 1972), p. 364.

Centres said that such women usually do not themselves raise the subject with their doctor, which indicates that the medical profession should therefore be especially watchful for post-partum depression.⁸⁸ More research is required.

Conclusions

71. The main conclusion that emerged from the evidence we received was that this most important area of human relationships does not receive the attention it deserves. While there was little criticism of the standard of medical care that women received, there was obviously widespread concern that psychological and emotional factors were being overlooked, with possible repercussions on future generations. We believe that this is an area of health care which should receive particular attention.

72. The Commonwealth Department of Health should initiate seminars around the countryside involving hospital administrators, obstetric health care professionals, childbirth educators and concerned voluntary organisations to discuss ways in which the emotional and social needs of the mother and child can be better respected and answered.

73. The education of doctors and nurses in the field of obstetric care should have regard to the social and emotional needs of the mother and child.

74. There should be more social workers or counsellors to talk to women in the pre-natal period, so that women who are troubled, tense or in need of practical assistance can be identified and helped. It would be helpful if all obstetric hospitals were to have access to a psychosocial unit, involving psychologists, psychiatrists and social workers. Migrant women should have better access to information and support, particularly as many are isolated from family and friends. Pre-natal classes should include discussions on emotional issues, child rearing, marriage relationships and contraception as well as giving information about childbirth. Pre-natal classes should be seen as an integral part of hospital services.

75. Hospital routine and activities should be made more flexible to allow for the variety of needs and desires of different women. There should be greater collaboration between childbirth educators, physiotherapists and medical and nursing staff. Hospital activities should be arranged so as to make the most of family support and involvement (especially the involvement of the father) in the process of childbirth.

76. The induction of birth for the convenience of the doctor rather than for medical reasons should be discouraged. The woman should be given the choice on induction, except in cases of medical necessity.

77. The question of choice also occurs in the use of medication. The administration of analgesics and anaesthesia should be decided in consultation with the mother. She should be advised of the effects that obstetrical medication may have on herself and her baby.

78. Hospitals should encourage parent-child bonding in every way possible. Mothers should be allowed to determine the amount of time they wish to spend with their babies, either by offering rooming-in facilities or giving women free access to their babies. Those women who wish to breast-feed should be encouraged in every way possible and feeding routines should allow the mother to breast-feed on demand, if desired, and to night-feed. Maternity care should be family centred and should encourage visits by fathers and other children. Women should have more opportunities to have their babies at home, should they so wish. Doctors, particularly general practitioners, should be alert and responsive to the problems of post-partum depression.

88. *ibid.*, p. 371; also Bruce Pitt, "Atypical" depression following childbirth', *British Journal of Psychiatry* 114 (1968), p. 1325.

7. Research Institute for the study of human sexuality, reproduction and fertility control

1. We have identified several areas where further research is needed in aspects of human sexuality and behaviour, fertility, contraception and abortion.
2. When considering sexuality we recommended further research into puberty, the menstrual cycle, the menopause and into male and female cycles in general. Much more needs to be known about sexually transmitted diseases, especially the most common ones which are least amenable to treatment.
3. In the field of contraception we seem to be far short of a simple and harmless method of contraception. Even if we had such a method there may be psychological barriers to its effective use. A considerable amount of research has been done into sub-fertility and infertility, but a great deal remains to be done.
4. Pregnancy testing is not yet reliable in the earliest stages of pregnancy. Further research is needed into the morbidity of pregnancy and childbirth.
5. To bring about the practical reality of effective fertility control we need to know a great deal more about the effects of existing methods of fertility control, about new methods and about the behavioural aspects of fertility control, including decision making. As we have seen every method has its disadvantages including problems in use. To develop new methods a great deal more research is needed.
6. All research is very costly; long-term funding is an important requirement, guaranteed for the duration of a project. The pattern of research in this field is that money is spent on chemistry, and by the companies which produce and market chemical forms of contraception.¹
7. A US Commission on population growth² recognised the need for research into basic reproductive biology. In their view fertility control has for too long been viewed as an unacceptable matter for public concern; pharmaceutical companies put \$68 million into research in 1965–69. The Commission thought that it was unrealistic to rely on this as the contraceptive needed may not offer a prospect of profits. They recommended that the highest priority be given to research into reproductive biology and to search for improved methods of fertility control, and that \$93 million be given in the first year.
8. A review of government and private expenditure in the reproductive sciences and contraceptive development in a number of western countries, including the US and Australia, considered that research in this field has never received a significant share of allocation for medical research or development assistance.³
9. The Lane Committee in the UK called for further research into abortion and its consequences and into contraception and education.⁴
10. Fertility control is the direct concern of every member of the community at some stage or other. Nevertheless research in this area appears not to be given sufficient priority in funding. To alter this situation the subject of research needs to be seen as respectable, desirable and urgently needed.

1. Evidence, p. 2101A, Dr Gwen Leavessy alleged manipulation of research finance by drug companies.

2. *Population and the American future*, 1969–72, pp. 105–6.

3. Roy O. Greep, Marjorie A. Koblinsky & Frederick S. Jaffe, *Reproduction and human welfare: a challenge to research* (MIT Press, Cambridge, Mass. and London, 1976), p. 427.

4. Lane report, vol. I, pp. 178–82.

11. Most research in reproduction and contraception in Australia is carried out in university departments with financial support from governments, private foundations and trusts.⁵ The percentage of total expenditure on medical research going to the field of human reproductive biology and contraceptive development rose from 1 per cent in 1966 to 8 per cent in 1973.⁶ This has to be considered in the light of the high number of GP consultations in such fields as preventive medicine, pregnancy care, family planning, contraception, sexual problems, sterilisation and other related matters.⁷

12. To emphasise the importance which the whole community should attach to this area of research we believe that an independently funded Research Institute should be established to promote, co-ordinate and carry out direct research into:

- human sexuality
- human reproduction
- fertility control

in all their aspects. Its functions should also include public education and the assessment of overseas research and its relevance in the Australian environment.

13. We have reached no final view as to the form of such an Institute. We think there would be much merit in establishing an Institute of Human Sexuality, Reproduction and Fertility Control as part of a new Australian Institute of Health.

14. The Institute should provide for clinical experience and would need clinical facilities for research purposes.

15. In our view the government should appoint a committee or working party to advise on the setting up of an independently funded Institute of the kind which we have outlined.

16. An important function of the Institute would be to make up-to-date information and techniques available to practitioners, especially those in country areas. In this it could support bodies involved in the ongoing training of doctors, such as the Family Medicine Program, post-graduate colleges and committees.

17. In the meantime there is a need to expand research funding in the area of sexuality, reproduction and fertility control. Current research should continue to receive support and the Department of Health should ensure the co-ordination of research and dissemination of information about projects in progress.

5. Commission^r consultation, William Walters, Associate Professor, Monash University, Melbourne, 21 February 1975.

6. *ibid.*

7. C. Bridges-Webb (ed.), *The Australian general practice morbidity and prescribing survey 1969 to 1974*, Special Supplement to the *MJA*, 2 October 1976.

Recommendations

We recommend that:

1. Schools, colleges and tertiary institutions should provide education programs in human relationships including sex and reproduction, sexual expression, sexual behaviour and its consequences, and the causes, symptoms and treatment of sexually transmitted diseases.
2. Teachers and counsellors should be ready to encourage discussion of sexuality and related matters and to offer referral to other agencies when appropriate.
3. Adult education programs should help people to identify and seek help with sexual problems.
4. Education for the medical and other helping professions should include training in identification of sexual problems and in treating those problems or referring them to specialists; where possible this education should be provided on a multidisciplinary basis.
5. More professionals, including clinical psychologists, therapists and social workers, should be trained, and sexual counselling units should be established in major centres as part of clinics or other facilities offering fertility control and related services (including family planning clinics, VD clinics and community health centres).
6. Consultation fees for these professional services should be refundable under Medibank and also covered by private health insurance.
7. The sexual needs of the handicapped and disabled people should be recognised and accepted in social planning and in the administration of institutions; isolation and segregation of the sexes should be avoided.
8. Training of medical, paramedical, educational and social work professionals should pay attention to the sexual needs and sexual options of handicapped and disabled people and to methods of help and counsel in these problems.
9. In-service training and information should be provided for medical and paramedical personnel involved in the care of the handicapped, disabled and aged, about their sexual needs.
10. Hospitals, institutions for the handicapped, FPAs and other educational institutions should provide information, education, rehabilitation and counselling services for the handicapped, disabled and aged in sexual matters.
11. Appropriate sex education should be provided for the disabled and handicapped of all ages by institutions responsible for their education and care.
12. Voluntary organisations, institutions and hospitals should be supported and encouraged to arrange social activities for the handicapped to meet and have opportunities for the development of personal relationships.
13. Professionals and institutions concerned with the care of the ageing should avoid isolation and segregation of the sexes.
14. Further research should be undertaken into puberty, menstruation and the menstrual cycle, the menopause and life cycles; information about these matters and the results of research should be incorporated into medical education and into public sex education programs.

15. Community health centres, family planning clinics and special clinics should be supported and equipped to deal with venereal disease and other sexually transmitted diseases; funding should be provided for counsellors to advise on the prevention of sexually transmitted diseases and on the importance of informing contacts and encouraging them to seek treatment.
16. Clinics treating sexually transmitted diseases should offer contraceptive advice and services and counselling on sexuality and sexual problems.
17. Sex education programs should include ethics and responsibility in human relationships and should stress the importance of advising partners of symptoms of sexually transmitted diseases and of encouraging them to seek treatment.
18. Public health education programs should be funded to provide information about all sexually transmitted diseases and about services for their treatment; special campaigns should be organised in high risk areas.
19. In prescribing the pill, doctors should advise on and be alert to complaints of side effects and disorders which may warrant discontinuance and use of another method.
20. All persons seeking advice on contraception should be given adequate information, counselling and advice on the choice of method, its proper use and effect and the possible side effects; the personal attitudes and beliefs of the person should be considered.
21. Information about a method of contraception, its use, effect and side effects should be included in every package of oral contraceptives, diaphragms and condoms and other contraceptive products; this information should be as full and as clear as possible and should also be in the main migrant languages.
22. Contraceptive services and the supply of contraceptive products should be more widely distributed geographically; opening hours should be more flexible and take account of working hours and shift work.
23. There should be more field workers in remote and rural areas with special training in related areas of gynaecology and sexuality.
24. Cultural factors should be given special attention in planning educational programs and in providing services.
25. The needs of young people should be given special attention in educational programs and services.
26. Educational and activational programs in contraceptive use should give special attention to the role of the male.
27. The use of the condom should be encouraged and restrictions on its distribution removed; education programs should emphasise its advantages of accessibility and its role in reducing the risks of VD.
28. Further surveys should be undertaken of the contraceptive practices of married couples, single women and men, and to bring up to date the information derived from the Australian Family Formation Project.
29. Further research should be undertaken into contraceptive technology and into the acceptability of the various methods of contraception.

30. The government should declare a basic policy that all persons should have easy access to information and advice about conception and contraception, and contraceptive services should be brought within the reach of all Australians.
31. A National Advisory Committee should be appointed to advise on policies for co-ordinating, integrating and expanding contraceptive services and on training programs for all professionals concerned in contraceptive services.
32. The government should ensure the extension of services by State or voluntary agencies, and should provide the funding and subsidies necessary to achieve this end.
33. The government should continue to fund womens community health centres as specialist centres providing primary medical care, counselling, education and undertaking research, subject to the requirement that each centre should establish a medical advisory board or similar body to advise on and review medical procedures.
34. Family Planning Associations should receive additional funding to establish instruction sessions in female cycles and the periodic abstinence methods.
35. Public hospitals should provide contraceptive advice, including information about services and supplies, instruction and counselling to post-partum and abortion patients.
36. Obstetric and gynaecology hospitals should include the full range of contraceptive services as part of their responsibility to their patients.
37. Training courses for pharmacists should cover contraception; special refresher courses on contraception should be organised for pharmacists. Pharmacists should be encouraged to display contraceptive items, or a sign indicating that these are available in the shop.
38. Funding should be made available for each State FPA to employ at least one domiciliary worker selected and trained for the position.
39. Resource centres and community information centres should carry information about contraceptive services; pilot programs should be established to test ways of using mobile clinics, especially in remote areas.
40. Occupational health workers should be trained to provide contraceptive information, advice and services at the workplace with special emphasis on the needs of migrant women. The training should cover aspects of sexuality and sexual problems.
41. Women having abortions should receive contraceptive counselling; services should be available. Abortion services should ensure that women having abortions are provided with information about contraception and encouraged to use some form of contraceptive protection.
42. The government should encourage and support the training and employment of family planning nurse practitioners.
43. Nurse practitioners should be employed by FPAs, by health departments in community health services, in hospital clinics and in VD clinics; nurse practitioners should be trained and authorised to undertake contraceptive procedures, including insertion of IUDs and prescribing oral contraceptives.
44. Nurse training courses should include programs on sexuality, contraception and human relationships; continuing education and refresher courses in these subjects should be provided for nurses.
45. The government should support by funding and otherwise the extension of the FPA training programs.

46. Adequate training in contraception should be required as a condition of funding for community health nurses and community health workers; they should provide contraceptive services especially where no other source is available.
47. Members of Aboriginal and migrant communities should be trained as community health nurses and community health workers and educators; training should cover all aspects of contraception.
48. Each Aboriginal community should be provided with trained community health nurses and allied workers.
49. The government should ensure that contraceptive services are provided in country areas through the community health program, community health educators and the Royal Flying Doctor Service.
50. Information on contraception should be prepared in the major ethnic languages and should be available to migrant social workers, ethnic communities and migrant women; information should accord with the migrants' cultural background; family planning clinics should have the services of interpreters or ethnic staff and counsellors.
51. Migrant women should be trained as voluntary workers to give family planning information to other members of their communities; and members of ethnic communities should be involved in planning contraceptive services for migrants.
52. Members of groups with special contraceptive needs, such as people in remote areas, migrants, Aboriginals and people in poverty, should be involved in planning services to meet those needs.
53. The government should promote responsible sexual behaviour by initiating and supporting programs:
- (a) to educate and inform people of all ages about sexuality, conception and contraception;
 - (b) to provide ready access by all people to contraceptive services and supplies suitable to their special needs;
 - (c) to motivate people to develop their ability to make responsible decisions.
54. The government should initiate and support nation-wide and local advertising campaigns to encourage the use of contraceptive services; it should also fund FPAs and other voluntary organisations to advertise their location and services.
55. The government, in co-operation with State governments, should ensure the wide dissemination of contraceptive educational literature and information about the location and nature of contraceptive services; the FPAs should be funded to produce this information, which should be in several languages. Translations should take account of cultural factors.
56. Booklets should be prepared for school leavers containing information about sexuality, conception, contraception, sexually transmitted diseases and about relevant community services.
57. Laws and regulations expressly restricting the advertising of contraceptives or fertility control services (including pregnancy testing) in the media should be repealed; it should be made clear that a reference to contraceptive services or products does not of itself breach any law about offensive publications.
58. The media should reconsider their policy in this area and the Department of Health should encourage them to accept advertisements relating to contraceptives and fertility control.

59. Family planning clinics and medical practitioners should be authorised to supply the contraceptives they prescribe.
60. Laws restricting the sale of non-prescription contraceptives such as condoms to a defined time or place should be repealed.
61. The government, in conjunction with State governments, should establish standards of training for nurses and other professionals in prescribing oral contraceptives and should give recognition to training programs; persons who have completed the appropriate training should be authorised to prescribe oral contraceptives and to fit IUDs and diaphragms.
62. The government should facilitate proper insurance provision to enable Family Planning Associations and similar services to employ trained personnel for the above purposes.
63. The government should investigate advertising in respect of contraceptive products and take steps to secure their withdrawal if it is unsubstantiated or inaccurate or misleading.
64. A joint Commonwealth-State committee should be established to set standards for contraceptive drugs and devices and to monitor those standards.
65. The government should take action to ensure that condoms on sale in Australia:
- (a) comply with appropriate standards;
 - (b) are date stamped;
 - (c) are in packets containing information about storage and use;
- and to ensure that all contraceptive products are distributed with appropriate instructions (in several languages) on use and effectiveness.
66. The Department of Health should encourage the development of a prompt and efficient pregnancy testing service by post or otherwise, and it should support the development and distribution of an effective and easy to use self-testing kit without the need of a prescription.
67. The law should be clarified to ensure that a medical practitioner acting with due care should not be criminally liable or civilly liable in respect of a sterilisation operation provided that the patient has consented to the operation with knowledge of the consequences, is 25, or is over 21 and the operation is performed not earlier than 6 months from the date when the request was first made in writing.
68. Where both spouses consent to an AID procedure the doctor acting with due care should be free of criminal or civil liability and the child born as a result of the procedure should be regarded for all purposes as the natural child of the parties.
69. Every woman who has an unwanted pregnancy should have access to pregnancy support and counselling services to advise her on all the alternatives open to her and to help her decide what course to take; support should be given for the provisions of such services.
70. Subject to what is said later about time limits, abortion should be free of legal regulation when performed by a registered medical practitioner at the request of the woman up to the end of the twenty-second week of pregnancy (measured from the commencement of the last menstrual period).
71. No doctor, nurse or other person should be required to take part in an abortion if he or she does not wish to do so.

72. Counselling services should be provided to every woman seeking abortion to ensure that she makes a free choice. These services should be supported by public funds.
73. The consent of a woman's husband or partner should not be required legally as a condition of an abortion.
74. It should be declared that no criminal proceedings will be taken against a registered medical practitioner who performs an abortion in appropriate conditions within the time limits specified.
75. Abortions should be authorised where mental or physical abnormality may result in serious handicap.
76. In all cases other than those mentioned in recommendations 70 and 75 abortion should be authorised only where it is necessary to preserve the life of the mother, or to avoid grave risk to her health; every effort should be made to preserve the life of any child born as a result of such termination.
77. Except in those circumstances where abortion is authorised, it should be an offence to destroy the life of a child capable of being born alive unless the act is done in good faith to preserve the life of the mother.
78. The government should ensure that women in all areas have access to adequate abortion services by encouraging and supporting the development of hospital services, clinic services and community health services.
79. Abortion services should be available as a general health service and as part of a range of fertility control services.
80. The Commonwealth and State governments should research and establish standards for the delivery of abortion services by hospitals and clinics. Guidelines should be established for the delivery of services in remote and rural areas. The need for interpreters and counsellors with language skills should be taken into account.
81. Obstetric and gynaecology public hospitals should set up as part of their services small abortion clinics, along the lines of the Preterm clinic in Sydney, performing abortions on an outpatient basis with full medical back-up facilities, counselling services and staff training facilities.
82. General hospitals, especially obstetric and gynaecology hospitals and those in country areas, should provide for abortion services to be delivered by staff selected and trained for that purpose, on a day patient basis, with counselling services.
83. Private abortion clinics should be encouraged to adopt voluntarily the standards of operation referred to above and funding provided for such services should be conditional upon compliance with these criteria.
84. In cases of early termination by vacuum aspiration where clinics do not provide general anaesthetic, women should be informed of this and referred elsewhere if they wish; women should have a choice of local or general anaesthetic.
85. Hospitals which are unable to offer amniotic replacement methods of abortion in the second trimester should refer patients to other hospitals or services able to offer this procedure; where possible hospital staff should receive training to enable the methods mentioned to be provided.
86. The government should ensure that information about the comparative safety of different methods of termination is widely distributed and should encourage hospitals to provide training and equipment to facilitate the use of the safest methods.

87. Abortion patients should be screened for blood type, venereal disease and cervical cancer.
88. Abortion patients should receive contraceptive advice at the time of termination; clinic and hospital policy should ensure that this is done by specially trained staff; contraception should be checked at a follow-up visit to either clinic, hospital or local doctor.
89. Counselling services should be available to every woman seeking termination of pregnancy; selected counsellors should receive specific training for the job and should be employed in every private and hospital clinic offering abortion services.
90. The government should encourage and support by subsidies or otherwise the cost of training and employing counsellors at clinic and hospital abortion services.
91. No person should be required to take part in an abortion procedure if this is contrary to his or her conscience.
92. In the selection and rostering of hospital staff for abortion services, the personal beliefs of those selected should receive due respect.
93. The data from our survey of intake procedures (Commission research report, no. 3) should be analysed and a report prepared.
94. When an abortion is considered necessary, it should take place as early in the pregnancy as possible, without administrative delays either in arranging consultation or performing the operation.
95. Steps should be taken to improve and expand the facilities for abortion and to ensure that information about these facilities is readily available to all women who seek abortion.
96. Abdominal methods of abortion should be avoided unless there are significant medical indications for such procedures.
97. Sterilisation should not be carried out in association with induced abortion unless there are strong medical, social or psychological indications for it. Most important, sterilisation should not be made a condition of obtaining an abortion.
98. Patients should be informed of the immediate and long-term risks attached to abortion and of any special risks which particularly apply to them; counselling should be available, and its importance stressed, to all women before and after abortion and to their husband or partner.
99. Women in special risk categories, such as women under 16, older women, women who have had many children, and women who seek successive abortions, should be given special attention in counselling and contraceptive advice.
100. A standard pattern should be adopted for the recording of complications related to abortion.
101. The data from our survey of the morbidity of abortions performed in hospitals and clinics (Commission research report, no. 2) should be fully analysed and the results published.
102. The WHO report on long-term consequences of abortion should be studied and further long-term studies of a similar kind should be undertaken in Australia.
103. Special services such as action centres should be provided to give information and advice to young people about sexuality, conception and contraception; 'outreach' programs should be introduced on an experimental basis with the aim of reaching young people in their local environment.

104. Young people should be actively involved in planning and organising such special services.

105. Education programs for young people should include information about sexuality, conception and contraception and about community services available to help young people in these matters.

106. Education and information material prepared for young people should adopt an easily understood and acceptable style and format.

107. Research should be undertaken in conjunction with services for young people, to monitor service provision and to determine the best ways of reaching young people most at risk.

108. The use of the condom by young people should be encouraged; young people should also receive instruction in the method of withdrawal.

109.

(a) A medical practitioner prescribing or supplying contraceptives or performing an abortion on a person aged 14 with the consent of that person should not incur criminal or civil liability by virtue of the absence of parental consent.

(b) In the case of a person under 14 years the doctor should not incur liability if the patient is sufficiently mature to appreciate the matter and consents to the operation or treatment, provided that the practitioner considered that the interests of the patient required the treatment or operation and it was impracticable to obtain parental consent.

110. Counselling should be available for all young people seeking contraceptive advice or treatment; access to counselling is essential to all contemplating abortion; counselling should stress the importance of involving the parents of a girl under the age of 14 in the discussions.

111. The Department of Health should initiate seminars throughout Australia to discuss ways in which the emotional and social needs of the mother at the time of childbirth can be better respected and better met. Such seminars should involve hospital administrators, obstetric health care professionals, childbirth educators and representatives of concerned voluntary organisations.

112. More emphasis should be placed on the emotional aspects of pregnancy and labour in medical and nursing schools, both at the undergraduate and post-graduate level. Obstetric hospitals should have access to a psychosocial unit, involving psychiatrists, psychologists and social workers.

113. Human relationships education should include pregnancy and childbirth and should discuss the social, emotional and physiological changes they induce.

114. Literature on pregnancy, childbirth and infant care should be made available in the main migrant languages and, to overcome language difficulties, audio-visual material should be used in pre-natal classes wherever possible. Interpreters should be available in classes involving a large number of migrants.

115. Hospitals, pre-natal clinics and private doctors should ensure that pregnant women are given opportunity to discuss their social and emotional needs and should offer help when problems are identified.

116. Hospitals should provide privacy for obstetric patients to consult with doctors.

117. The government should fund pre-natal classes which prepare women and men for the emotional and social adjustments they will have to make, as well as for the physical changes that will occur. The classes should discuss contraception, parenthood and marriage relationships.

118. Pre-natal classes should be seen as an integral part of hospital and health services.

119. The induction of birth for convenience rather than for medical reasons should be discouraged; women should be given the choice on induction, except in cases of medical necessity.

120. The administration of analgesics and anaesthesia should be decided in consultation with the mother. She should be advised of the effects that obstetrical medication may have on herself and her baby.

121. Hospitals should encourage consultation between childbirth educators, physiotherapists and medical and nursing staff, so that a consistent approach is adopted to ensure that mothers presenting at hospital for the birth of a child are aware of the routine they can expect.

122. Fathers should be allowed to attend the birth of their babies, subject to the wish of the mother. In the absence of the father, mothers should be allowed to nominate someone else. Unmarried fathers should not be treated differently from legal fathers.

123. Hospitals should encourage breast-feeding and should allow women to breast-feed on demand or to night-feed should they desire.

124. Hospitals should encourage parent-child bonding, particularly in the early stages of infant life. In premature birth, or other cases requiring special care, the mother should be trained to assist in looking after her baby.

125. Rooming-in facilities should be offered wherever possible; otherwise mothers should be allowed ready access to their babies.

126. Hospitals should allow siblings to visit their mother in maternity hospitals and units.

127. Health care professionals who are in contact with women during the post-partum period should be sensitised to the need to recognise the early symptoms of emotional disturbance, particularly depression.

128. Maternity hospitals should provide programs on child rearing for parents in the period immediately following the birth of their child.

129. More research should be conducted into the effect of psychological and emotional factors on the course and outcome of pregnancy.

130. Further studies should be made into the effects upon the newborn of drugs dispensed to the nursing mother.

131. Health services should consider developing midwife services to allow childbirth at home, provided such services are backed by ambulance and transfusion services.

132. The government should establish an independently funded Research Institute for the study of human sexuality, reproduction and fertility control; a committee should be appointed to advise the government on the setting up of the Institute, with

the functions of promoting, co-ordinating and carrying out direct research and of disseminating information to the professions and the public about research developments in Australia and overseas.

133. Current research projects in the fields of human sexuality, reproduction and fertility control should continue to receive funding and further funds should be made available for research in these areas.

Annexe IV.A

Extract from *Everything you've always wanted to know about VD* (Health Commission of NSW, 1974)

Don't spread the bad news

One of the most important ways of preventing the spread of syphilis and gonorrhoea is for anyone who is infected to be treated so they can't infect anyone else. So if you are diagnosed as having syphilis or gonorrhoea, it is important that you tell the person who infected you or anyone that you may have infected so they can be cured too. These people may not have any symptoms and not know they have VD.

If for any reason you can't tell them, please help them by supplying their names and addresses or any other information you may have to your doctor so he can arrange for them to be treated too. All such information is treated in the strictest confidence.

You're not putting them in—you're doing them a favour and saving them the embarrassment of infecting someone else (maybe a regular sex partner!).

How can VD be prevented?

There is no vaccine or medicine which can protect you against gonorrhoea or syphilis. Taking unprescribed doses of antibiotics or attempting any other type of self-treatment will not prevent or cure VD; and it is dangerous, because it may lead to an incorrect diagnosis by hiding the symptoms and let the infection go untreated. Having had VD before does not give you any immunity against catching it again unfortunately!

Never have intercourse with anyone who has an obvious discharge, sores on the sex organs or a rash on the body. Remember, though, that a person may appear perfectly healthy in every way and still have VD.

For men the wearing of a condom (French letter) during intercourse provides good protection against infection if properly used. The condom must be smoothed down over the erect penis right to the base, leaving enough space in the top for the ejaculated sperm. After intercourse hold the rim of the condom as your penis withdraws from your partner's body so the condom doesn't slip off. Urinating and washing with soap immediately after intercourse may also help, though not always effective. It cannot be relied upon.

For women douching with a mild antiseptic or weak vinegar solution (1 tablespoon to 1 pint of water) may help. The pill, foam and jelly preparations, suppositories and contraceptive devices (except for the French letter or condom) don't protect you against infection at all.

Be extremely careful if you do use a douche, because if you use it roughly or incorrectly you could do some damage. If you aren't sure how to use one ask your doctor.

If you have intercourse with many different people you should have regular tests.

Annexe IV.B

Extract from 'How Clanger Molloy caught the Clap and gave it to his girlfriend!'
(WA Health Education Council)



Annexe IV.C

Definitions of some terms used in Part IV

This list defines terms used in this part. A list of terms as specifically used in Annexe IV.P appears at the end of that annexe.

Abortion—termination of pregnancy before the foetus has attained viability, i.e. become capable of independent extra-uterine life

Amenorrhoea—absence of menstruation

Amniotic replacement—a method of induced abortion in which part of the amniotic fluid is withdrawn and replaced with saline or other solution (see Annexe IV.M, methods of abortion)

Amniotic sac—surrounds the foetus with amniotic fluid

Cervix—the entrance to the womb or uterus to be found at the top of and within the vagina

Contraception—methods of fertility control which prevent conception or implantation

Dilatation and curettage—a method of inducing abortion in which the cervix is dilated or stretched open, and the conceptus removed using a curette, or spoon-shaped instrument

Episiotomy—an incision through the lower wall of the vagina to prevent tearing during delivery of the baby

Family planning—planning the number and spacing of children forming a family unit

Fecundability—The probability of conception (the rate is usually calculated as the monthly probability of conception per 100 women)

Fecundity—the potential a woman (or man) may have to produce children

Fertility—the actual live births occurring for a particular person

Fertility control—the regulation of the number of births a woman has

Foetus—the human embryo from conception to delivery

Hysterectomy—an operation to remove the uterus

Hysterotomy—an operation which involves opening the abdomen and uterus to remove a foetus

Menstrual regulation/menstrual extraction—removal of the contents of the uterus by vacuum aspiration before diagnosis of pregnancy

Morbidity—physiological or psychological disease

Parity—describes the number of viable foetuses a woman has delivered (sometimes used to describe the number of live births)

Prostaglandin induction—the initiation of labour by the introduction of a hormone compound, prostaglandin, into the amniotic sac

Sexuality—the sexuality or sexual nature of a person includes the following aspects:

- the male or female characteristics and functions of the reproductive organs and other physiological differences related to these
- the possession of sexual powers or capability of sexual feelings; the ability to respond sexually
- sexual behaviour including intercourse between the sexes
- perception of one's own sexual nature; behaviour related to this perception

Trimester—a pregnancy is divided into three trimesters or periods of approximately 12 weeks each

Uterus—the womb

Vacuum aspiration—a method of inducing abortion in which the cervix is dilated or opened and the contents of the uterus withdrawn by means of suction

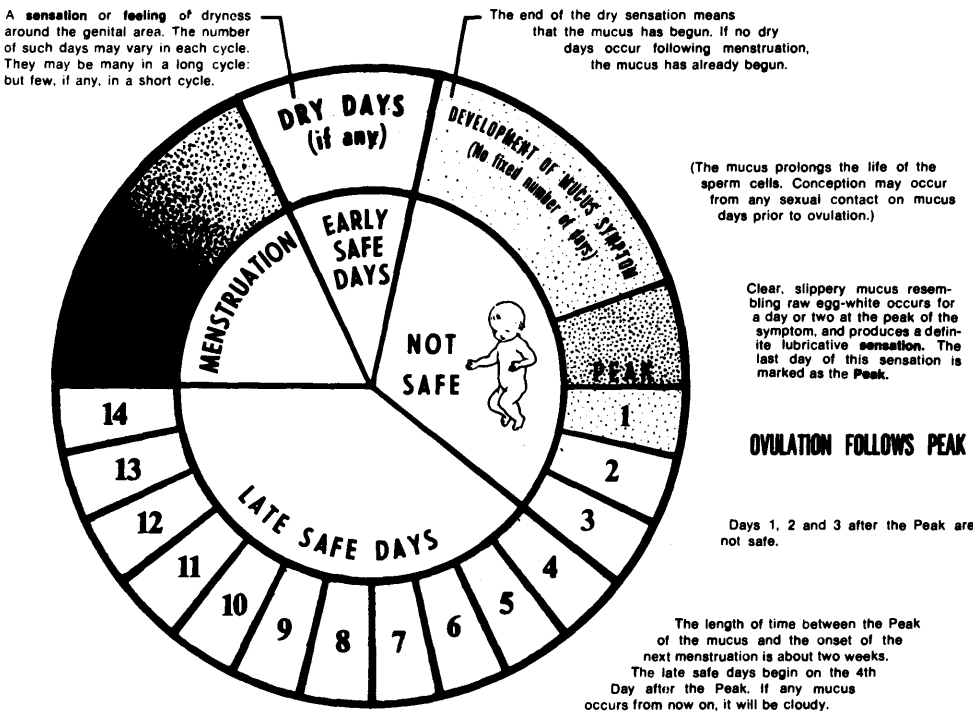
Viability—the quality of having life or capability of living outside the mother's body

Annexe IV.D

The ovulation method: Instruction sheet: A note for teachers by Dr Lyn Billings

THE OVULATION METHOD

The Safe Period Based on the Mucus Symptom



**A NATURAL METHOD OF ACHIEVING OR AVOIDING PREGNANCY,
WHICH IS HARMLESS, RELIABLE AND MORALLY ACCEPTABLE.
NO MEDICATION OF ANY KIND IS NECESSARY.**

INSTRUCTIONS

1. All sexual contact must be avoided in the first cycle if correct information is to be obtained.
2. When a period commences, write the date in the margin on the left, e.g., 29 Sept., '71, and write the day of the week in the first compartment. Continue writing the names of the following weekdays, one day to each compartment, across the page, e.g., Friday, Saturday, etc.
3. To record the first day of the period, stick a red stamp in the first compartment covering the name of the weekday. On each successive day of the period, stick another red stamp in the next compartment.
4. When the period stops, and if there is **a sensation of dryness** in the genital area around the vagina, stick a dark green stamp in the next compartment. The best time to do this is at the end of the day.
5. Continue with the dark green stamps each day until the feeling of dryness stops. **These dry days are safe days**, and vary in number in different cycles. If no dry days occur, do not have intercourse.
6. A dry day may be difficult to recognise if intercourse has occurred on the previous day. If doubt exists, avoid the day.
7. When the sensation of dryness has gone, this means that the mucus has begun. Now stick on a white stamp each day. The white stamp has an imprint of a baby, because any sexual contact may now cause conception.
8. Over the next few days the mucus usually **looks** cloudy and **feels** sticky. There may be abdominal pain or, rarely, a little bleeding.
9. Close to the ovulation there is **a sensation of lubrication** in the genital area around the vagina as the mucus becomes slippery. There may be pain in the side, and the mucus usually becomes clearer and stretches like raw white of egg.
10. **The last day of the slippery, lubricative mucus is the Peak Symptom. At this point fertility is greatest.**
11. On the first day past the Peak Symptom the mucus will become cloudy and sticky again. At this point indicate with 'X' the day on which you think you experienced the Peak Symptom. If another day of slippery, lubricative mucus occurs after this, you have misjudged the Peak and will need to mark the record again.
12. Continue to stick on a white stamp each day, or, if the mucus stops, stick on a pale green stamp with the imprint of a baby, until three days past the Peak Symptom.
13. On the fourth day past the Peak Symptom, stick on the dark green stamps again. **From now on, every day of the cycle is completely infertile and safe for intercourse, even if some cloudy mucus is present.**
14. In some long cycles there may be a succession of days, three or four or even more, when the mucus is present. Then the mucus may stop for a number of days, then begin again. Until you are sure that you can recognise the Peak Symptom, wait until the fourth day past these patches before resuming intercourse, and continue to restrict intercourse to the dry days.
15. The next period should occur about two weeks after the Peak Symptom. When it arrives, verify the accuracy of your identification of the Peak by checking this two weeks' interval.
16. When this next period begins, start a new line in the same way as before. Remember to stick on a stamp for every single day.
17. Each cycle has its own pattern. Don't expect it to match any other cycle exactly.
18. It is wise to record on the chart the last act of intercourse ahead of the "baby days", and the first act after they are ended. Any error of application will then be quickly observed, and not be repeated.
19. If there seems to be any difficulty, consult other women who are experienced in the Method.

For further information consult

THE OVULATION METHOD

by Dr. John J. Billings,

published by

Advocate Press, 143 a'Beckett Street, Melbourne 3000, Australia

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A note for teachers by Dr Lyn Billings

All women have a cervical mucus pattern whenever they ovulate. Most of them will recognise and identify the symptom as soon as they hear a competent description of it. It is never difficult to find amongst a group of women several who have the capacity to impart their knowledge to others and to inspire confidence.

The basic problem for the male teacher is that he has never had the personal experience of ovulation, and he may therefore only dimly appreciate what he is trying to describe. For all teachers, men and women, there may be the problem that the woman is so familiar with the cervical mucus that she has already attributed it to something other than ovulation, and therefore imagines that the teacher must be talking about something else. For example, some women have thought that the mucus is an abnormality, perhaps an infection, and have sought treatment for it. When the mucus is present, it frequently causes increased sexual inclination, and the woman may have concluded that the mucus has resulted from thinking about sexual activity. In fact, any secretions which may accompany sexual intimacies are quite different from the cervical mucus and they are not a source of confusion.

As soon as the woman understands that the mucus is a normal, healthy accompaniment of ovulation, additional detail is able to be provided. The mucus warns of the approach of ovulation and a particular change in the nature of the mucus occurs very close to the precise time of ovulation. A woman can easily recognise this progress to what many have described as a 'peak', when the mucus is clear, elastic and slippery, after which it becomes cloudy and tacky again. As this special sort of mucus occurs close to a peak level of certain chemicals (the oestrogens) in the system, it is appropriate to use the expression 'the peak symptom'. The study of the mucus symptom is important not only because of the information it gives about the approach of ovulation and its occurrence, but because the mucus has an important role in facilitating conception by its effect upon the sperm cells. It is for this reason that all sexual contact is to be avoided when the mucus is present.

Depending upon the length of the cycle a number of dry days will occur after the menstrual period. The dryness is appreciated as a positive sensation of nothingness, as the woman goes about her normal activities. The dryness is followed by a gradual change to a wet or to a sticky sensation, or the onset of the mucus symptom may be marked by a lump of cloudy mucus which has been resting like a plug in the neck of the womb. Women must be warned that this plug, if it is noticed, is not the peak symptom, but rather the beginning of the mucus symptom. The mucus may also begin as sticky, yellowy thread-like mucus of very small quantity. As the days go on the mucus may become thinner, clearer, stretchy and perhaps more copious, taking on the appearance of raw egg-white, with a characteristic sensation of slipperiness. When the mucus becomes cloudy and sticky again it is recognised that the peak has been passed.

The time of the peak symptom is the time of maximum fertility and this information is very useful to those women who have had difficulty in achieving pregnancy.

In any big audience there will always be a few women who will feel doubtful of their ability to use the method successfully. Some will say that they have a continuous mucus. Some will say that they have none at all. In all these cases success will follow if the woman will co-operate to the extent of making a daily record. It is now that the woman who has learnt the method properly by charting her own cycles will be really able to help others overcome any difficulties.

At the end of the initial instruction each woman who wishes to learn the method can commence immediately, recording the present day by the appropriate stamp, locating it in its correct relationship to the previous menstrual period, childbirth etc.

When a long cycle is recorded, there will occur a series of dry days interspersed with days on which mucus is observed. For these mucus days the white 'baby stamps' will have been used. It will be evident in retrospect that the only truly fertile days were in proximity to ovulation. When ovulation occurs a menstrual period can be expected about two weeks later. Sometimes there may be one or more menstrual periods without any ovulation. The avoidance of all sexual contact on days marked with a 'baby stamp' will ensure that there is no likelihood of conception.

During breast-feeding, in long irregular cycles, when giving up contraceptive medication, when approaching the menopause, the rules are always the same. If any dry days occur between the period and the time of ovulation, these days are safe for intercourse. During lactation, for example, there may be weeks or months with only occasional days of mucus, and as long as the sexual contact is avoided on those days, conception will not occur; the ovulation method is ideally adaptable for use during lactation.

If there is a prolonged discharge due to some pathological condition it is advisable and helpful that the necessary treatment be applied. With practice and experience the normal mucus can still be recognised by the changes it produces in the discharge, even before the discharge is eradicated. If the problem seems to be a long mucus symptom, restricting the freedom of intercourse, the woman can learn to distinguish progressive changes that occur in the nature of the mucus as she draws closer to ovulation; when she has learnt this, she will be able to use with safety some of the days after the symptom has begun. She must always remember that when the mucus becomes clear or slippery or stretchy, all quite definite changes, she has been warned of possible fertility.

It may be helpful for the teacher group to meet for discussion from time to time, and for them to have a doctor who understands the scientific aspects of the ovulation method available for referral of any woman with gynaecological disorders. Beyond this there will remain only those few cases where the complaint of continuing difficulty is really expressive of a psychological problem, perhaps a lack of any real desire to determine the days of infertility with certainty, and in these circumstances it is marriage counselling and not advice about family planning that is really required.

The husbands of the women who are being instructed should be given a good general understanding of the method. Many husbands come to recognise when their wives are close to ovulation; they may notice an increase in physical energy, or changes in behaviour which may be somewhat intangible. With the stamp record also available for scrutiny, they understand when abstinence is required. The husbands of the teachers can make a very important contribution, by their account of the success of the method from their own point of view.

Annexe IV.E

Tables showing mortality rates for methods of fertility control with explanatory notes

- (a) Annual number of live births, induced abortions and deaths associated with control of fertility, per 100 000 non-sterile women by regimen of control and age of women
- (b) Annual number of deaths among women using specified methods of fertility control, per 100 deaths among women using no fertility control method, by regimen of fertility control and age of women
- (c) Total number of live births, induced abortions and deaths associated with control of fertility and no control that are expected over the remainder of the reproductive years, per 100 000 non-sterile women by regimen of control, at selected ages of women when starting family limitation

Source: C. Tietze, J. Bongaarts and B. Schearer, 'Mortality associated with the control of fertility', *Family Planning Perspectives* 8, 1 (1976).

(a) Table—Annual number of live births, induced abortions and deaths associated with control of fertility, per 100 000 non-sterile women, by regimen of control and age of women

| Regimen of control and outcome | Age group | | | | | |
|--|------------|------------|------------|------------|------------|-------------|
| | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 |
| A. No control | | | | | | |
| Live births | 50 700 | 61 400 | 58 760 | 55 780 | 47 170 | 31 680 |
| Birth-associated deaths | 5.5 | 5.2 | 7.1 | 14.0 | 19.3 | 21.9 |
| B. Abortion only | | | | | | |
| Induced abortions | 99 500 | 133 130 | 131 770 | 122 700 | 106 760 | 65 090 |
| Abortion-associated deaths | 2.3 | 2.5 | 2.5 | 5.2 | 9.8 | 6.6 |
| C. Oral contraception, no abortion | | | | | | |
| Live births | 1 150 | 1 940 | 1 910 | 1 770 | 1 350 | 650 |
| Birth-associated deaths | 0.1 | 0.2 | 0.2 | 0.4 | 0.6 | 0.4 |
| Method-associated deaths | 1.3 | 1.3 | 1.3 | 4.8 | 6.9 | 24.5 |
| Total deaths | 1.4 | 1.5 | 1.5 | 5.2 | 7.5 | 24.9 |
| D. IUD, no abortion | | | | | | |
| Live births | 1 150 | 1 940 | 1 910 | 1 770 | 1 350 | 650 |
| Birth-associated deaths | 0.1 | 0.2 | 0.2 | 0.4 | 0.6 | 0.4 |
| Method-associated deaths | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Total deaths | 1.1 | 1.2 | 1.2 | 1.4 | 1.6 | 1.4 |
| E. Traditional contraception, no abortion | | | | | | |
| Live births | 10 260 | 16 050 | 15 710 | 14 630 | 11 430 | 5 860 |
| Birth-associated deaths | 1.1 | 1.4 | 1.9 | 3.7 | 4.7 | 4.0 |
| F. Traditional contraception and abortion | | | | | | |
| Induced abortions | 13 720 | 20 580 | 20 360 | 19 630 | 15 610 | 8 400 |
| Abortion-associated deaths | 0.3 | 0.4 | 0.4 | 0.8 | 1.4 | 0.8 |

Explanatory note

Panel A shows the number of live births and associated maternal deaths that can be expected if no method of fertility control is used. Panel B indicates the number of abortions and deaths associated with abortion that occur if abortion is the only method of fertility control.

The numbers of abortions required are about twice the number of births expected in the absence of all methods of control (panel A), reflecting the shorter duration of pregnancies or post-gestational anovulatory periods that permits an earlier return to the fecundable state.

The number of deaths is less than half that expected for panel A however. This is because:

. . . (the) age-specific mortality ratios after early abortion are less than one-fourth of the corresponding ratios of maternal mortality associated with pregnancy and childbirth.

In a footnote, the authors remind their readers that:

. . . the age-specific mortality ratios (for abortion) used in this report correspond to a level of mortality about twice as high as that achieved in the United States in 1972-73.

When either oral contraceptives or the IUD are used (panels C and D), even without abortion as a back-up in case of failure, the number of live births, birth-associated deaths and method-associated deaths expected is substantially reduced.

When the condom or diaphragm are used (panel E) the number of live births expected is higher than for pill or IUD users, hence there are more birth-associated deaths. Overall mortality (method and birth related) is similar for all three panels in the younger age groups but the IUD is least hazardous for women over the age of 40 and the pill the most hazardous.

In contrast, use of the traditional methods plus abortion produces the lowest overall death rates for all regimens of control and all age groups. In this panel (F) it is assumed that all pregnancies are terminated and there are no method-related deaths. As Tietze et al. point out, the greatest reduction to risk of death is for women aged 40-44 choosing this regimen as an alternative to no control or fertility control using the pill.

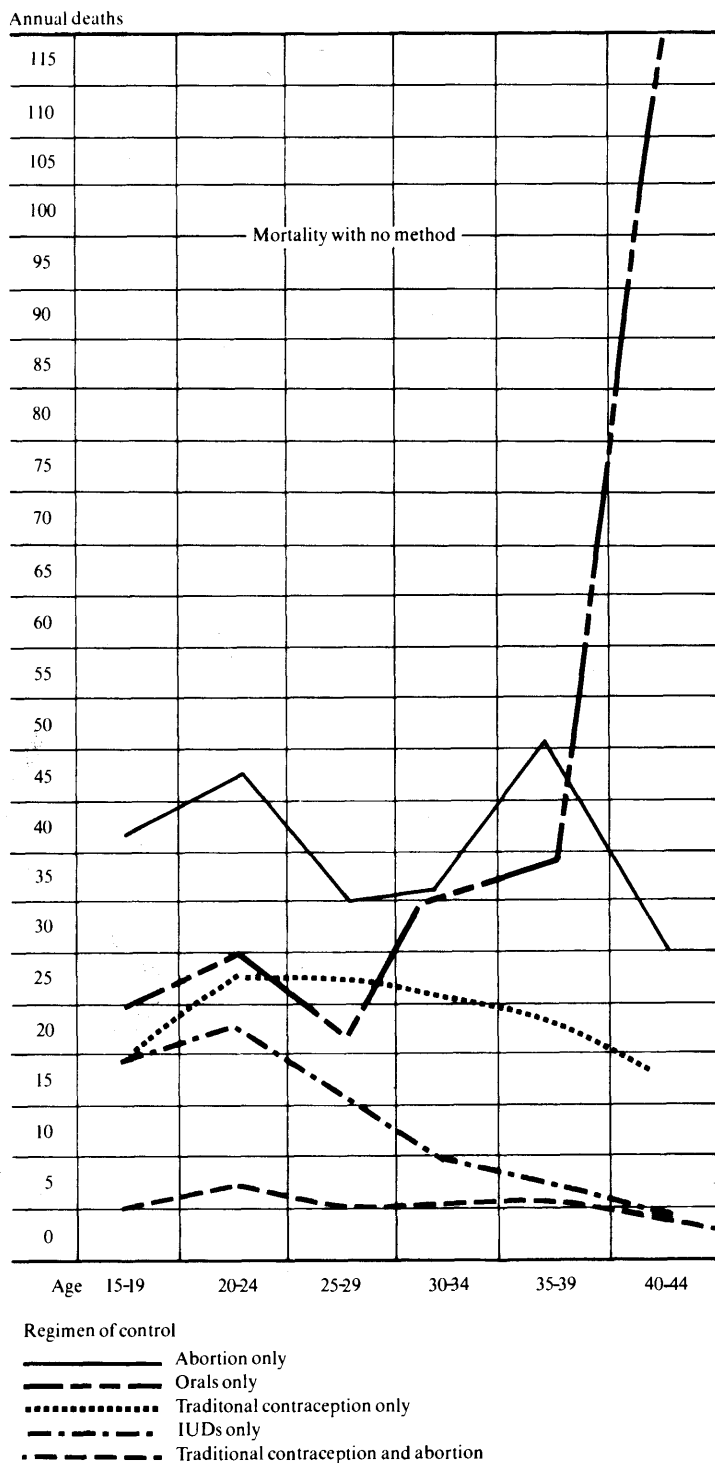
The risk of death from these alternatives is dramatically illustrated in the graph (b).

Slightly lower rates of mortality for the IUD and pill would be expected if abortion were used as a back-up for these methods. Mortality would be reduced by 20-30 per cent for pill users and 7-8 per cent for IUD users; the rates are not higher since the majority of deaths for these panels are method related rather than birth related.

In a further calculation, Tietze and colleagues produced a table (c) which shows:

. . . live births, induced abortions and deaths associated with control of fertility that are expected for the remainder of the child-bearing period, by regimen of control for women starting family limitation at the exact ages of 25, 30, 35 and 40 years . . . All women are assumed to be non-sterile at the age shown in the column heading and to remain sexually active throughout the period under consideration.

(b) Graph—Annual number of deaths among women using specified methods of fertility control, per 100 deaths among women using no fertility control method, by regimen of fertility control and age of women



(c) Table—Total number of live births, induced abortions and deaths associated with control of fertility and no control that are expected over the remainder of the reproductive years, per 100 000 non-sterile women^(a), by regimen of control, at selected ages of women when starting family limitation

| Regimen of control and outcome | Age at starting family limitation | | | |
|--|-----------------------------------|--------------|--------------|--------------|
| | 25 | 30 | 35 | 40 |
| A. No control | | | | |
| Live births | 861 380 | 598 060 | 348 150 | 149 860 |
| Birth-associated deaths | 265.6 | 244.9 | 188.9 | 117.6 |
| B. Abortion only | | | | |
| Induced abortions | 1 903 460 | 1 311 560 | 761 070 | 305 360 |
| Abortion-associated deaths | 100.5 | 92.2 | 72.0 | 30.8 |
| C. Oral contraception, no abortion | | | | |
| Live births | 25 740 | 17 060 | 8 990 | 3 040 |
| Birth-associated deaths | 7.3 | 6.5 | 4.7 | 2.4 |
| Method-associated deaths ^(b) | 187.5 | 181.0 | 157.0 | 122.5 |
| Total deaths | 194.8 | 187.5 | 161.7 | 124.9 |
| C¹ OCs to age 40, followed by traditional contraception, no abortion | | | | |
| Live births | 43 570 | 36 670 | 28 930 | na |
| Birth-associated deaths | 21.3 | 21.1 | 20.3 | na |
| Method-associated deaths | 65.0 | 58.5 | 34.5 | na |
| Total deaths | 86.3 | 79.6 | 54.8 | na |
| D. IUD, no abortion | | | | |
| Live births | 25 740 | 17 060 | 8 990 | 3 040 |
| Birth-associated deaths | 7.4 | 6.5 | 4.7 | 2.4 |
| Method-associated deaths ^(b) | 20.0 | 15.0 | 10.0 | 5.0 |
| Total deaths | 27.4 | 21.5 | 14.7 | 7.4 |
| E. Traditional contraception, no abortion | | | | |
| Live births | 214 730 | 143 610 | 77 140 | 27 320 |
| Birth-associated deaths | 61.2 | 55.3 | 40.0 | 21.4 |
| F. Traditional contraception and abortion | | | | |
| Induced abortions | 287 660 | 195 890 | 106 900 | 39 200 |
| Abortion-associated deaths | 15.4 | 13.9 | 10.7 | 4.0 |
| G. Deaths associated with tubal sterilisation | | | | |
| Low estimate | 10.0 | 10.0 | 12.5 | 15.0 |
| High estimate | 20.0 | 20.0 | 25.0 | 30.0 |
| H. Deaths associated with vasectomy | 0.0 | 0.0 | 0.0 | 0.0 |

(a) Not sterile at ages indicated in column headings.

(b) Use of regimen assumed until age 45.

Note: na = not applicable.

Annexe IV.F

Table IV.F.1 Services offered by FPAs

| | Contra- ceptive advice + supply | Termin- ation of preg- nancy | VD treat- ment | Preg- nancy testing | Pathology | | Meno- pause treat- ment | Counselling re | | |
|---------------------------------|--|---------------------------------------|----------------------|---------------------------|---------------|-------|----------------------------------|----------------|------------------|---------------------------------------|
| | | | | | Pap smears | Other | | men- opause | adol- escence | psycho- sexual infer- tility |
| New South Wales | * | * | | * | * | * | * | * | * | * |
| Victoria | * | * | | * | * | | * | * | * | * |
| Tasmania | * | | | * | * | * | * | * | * | * |
| Western Australia | * | | * | * | * | * | * | * | * | * |
| Queensland | * | | | * | * | * | * | * | * | * |
| Australian Capital Territory | * | * | | * | * | | | * | * | * |
| South Australia | * | | | * | * | | * | * | * | * |
| Northern Territory | * | | * | * | * | * | * | * | * | * |

Table IV.F. 2 FPA's: Number of visits; number of new patients

| | Visits | | | | New patients | | | |
|-------|--------|--------|--------|---------|--------------|--------|--------|--------|
| | 1975 | 1974 | 1973 | Total | 1975 | 1974 | 1973 | Total |
| NSW | 30 944 | 23 413 | 18 000 | 72 357 | 9 692 | 8 430 | 7 000 | 25 122 |
| Vic. | 6 631 | 4 128 | 2 142 | 12 901 | 2 926 | 1 772 | 780 | 5 478 |
| Tas. | 1 365 | 571 | 63 | 1 999 | 567 | 312 | 43 | 922 |
| WA | 6 196 | 4 555 | 2 601 | 13 352 | 2 459 | 1 799 | 1 227 | 5 485 |
| Qld | 8 510 | 6 266 | 2 846 | 19 622 | 2 939 | 2 030 | 1 237 | 6 206 |
| ACT | 4 649 | 2 919 | 1 310 | 8 878 | 2 047 | 1 202 | 645 | 3 894 |
| SA | 14 951 | 11 824 | 7 596 | 34 391 | 3 621 | 3 304 | 2 407 | 9 332 |
| NT | 916 | 619 | 61 | 1 596 | 518 | 381 | 44 | 943 |
| Total | 74 162 | 54 295 | 34 619 | 165 296 | 24 769 | 19 230 | 13 383 | 57 382 |

Table IV.F. 3 FPA's: Cost of visits

| | Direct cost per patient visit (not including administrative costs) | Indirect cost per patient visit (administration, education, training) |
|------------------------------|--|--|
| | \$ | \$ |
| New South Wales | 6.27 | 4.09 |
| Victoria | 5.47 | 19.11 |
| Tasmania | na | na |
| Western Australia | 6.5 | 10.7 |
| Queensland | 6.94 | 11.20 |
| Australian Capital Territory | 5.31 | 12.19 |
| South Australia | 7.40 | 2.00 |
| Northern Territory | 3.30 | 5.11 |
| | The cost is comparable with the fee for a visit to a GP | A measure of all the other services Associations are endeavouring to offer |

na: Information not available

Table IV.F.4 Sources of finance for FPAs, 1975-76

| | Cwlth Dept Health— direct grant | Cwlth Dept Health via AFFPA | Cwlth Dept Health— health program grant | Hospitals and Health Services— Commission— community health grant | State or Territory Health Dept | Medibank refunds | Other revenue (subscrip- tions, donations, sales) | Total |
|------|--|-----------------------------------|---|---|--------------------------------------|---------------------|--|-----------|
| | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| NSW | 52 872 | 44 201 | 349 175 | 56 249 | 5 000 | 57 624 | 48 577 | 613 698 |
| Vic. | 22 398 | 38 799 | 112 841 | | 20 000 | 10 987 | 35 573 | 240 598 |
| ACT | 19 322 | 13 715 | 55 777 | | 23 831 | 10 487 | 22 537 | 145 669 |
| Tas. | | 19 246 | 10 620 | | 7 500 | 2 322 | 2 603 | 42 291 |
| NT | 1 164 | 10 950 | 12 680 | | 3 813 | | 1 471 | 30 078 |
| Qld | 24 322 | 24 250 | 145 715 | | 50 000 | 22 692 | 24 820 | 291 799 |
| SA | 66 268 | 18 550 | 123 318 | | 112 500 | 16 900 | 60 077 | 397 613 |
| WA | 17 952 | | 69 356 | | 6 500 | 9 203 | 11 798 | 114 809 |
| | 204 298 | 169 711 | 879 482 | 56 249 | 229 144 | 130 215 | 207 456 | 1 876 555 |

Source: 1975-76 Audited financial statement of each FPA.

Annexe IV. G

Extract from Remberg et al, 'Radio and television spot announcements for family planning worldwide', *Media Monograph Series*, no. 3 (1975) showing some obstacles to effective contraception and media announcements to overcome them

Obstacle 1 Fears of permanent damage to health from prolonged use of pill, IUD or other contraceptives

Linda:

Good afternoon, Mrs Blake. How are you? Say, what brings you to this end of town?

Mrs Blake:

Oh, hi, Linda. I was just over at the health centre.

Linda:

What for? Are you sick?

Mrs Blake:

No, I'm fine. I just had an IUD inserted by the doctor.

Linda:

Oh! Mrs Blake, aren't you afraid there'll be some side effects that will affect your health?

Mrs Blake:

When I first thought about getting an IUD—a couple of weeks ago—I was worried about that. I had heard all sorts of rumours. But after I talked to the doctor and studied some publications, I found out that the IUD isn't at all harmful. Besides, the people at the clinic really take care of you. They gave me a thorough examination to make sure I didn't have any disorders that might make accepting the loop difficult.

Linda:

Oh, that's news to me. I've been wondering about the IUD myself. Maybe I'll go to the clinic myself and ask for some information.

Announcer:

This message is brought to you by your local family planning centre. We are concerned about your health. Don't be misled by unreliable rumours. For the facts of family planning, contact your local health clinic.

Obstacle 13 Tolerance of the low status of women and weak support of the movement for womens rights

SFX (The track is continuous, with a narrative continuity of its own)

Announcer (male): The following message is for husbands.

Sounds of children, market, washing, etc., become progressively more hectic.

This is what it sounds like to be in charge of running a household. You might not recognise all of these sounds, but your wife probably would. Taking care of your home is her biggest responsibility. It's quite a

Infant's cry punctuates the pause after 'child' followed by wife talking loudly, by 'irritable' she's screaming. Segue peaceful sounds, or possibly easy music.

Track out.

job. And every time you have another child, the job gets tougher. That's why, as your family gets bigger and bigger, your wife gets tired and irritable. But there's really no reason to put an unnecessary burden on your wife—and on yourself. Modern family planning methods make it possible to plan the growth of your family—how many kids you want to have, and when you want to have them. Family planning can be a help to the *entire* household, and there's no better person to discuss it with than the world's foremost authority on your household—your wife. This message is brought to you by your local family planning clinic. After you've talked to her, visit us.

Annexe IV.H

Male and female sterilisation (Medical Benefits Schedule statistics based on estimated 75m services on full year basis 1976-77)

Summary of data

| | NSW | Vic. | Qld | SA | WA | Tas. | Aust. |
|----------------------|--------|--------|-------|-------|-------|-------|--------|
| 1. Male | 9 356 | 5 682 | 5 013 | 3 211 | 3 318 | 478 | 27 058 |
| 2. Salpingectomy (F) | 3 046 | 2 049 | 928 | 1 011 | 1 339 | 82 | 8 455 |
| 3. Sterilisation (F) | 11 542 | 7 321 | 3 114 | 3 019 | 3 496 | 1 271 | 29 763 |
| Female | 14 588 | 9 370 | 4 042 | 4 030 | 4 835 | 1 353 | 38 218 |
| Total | 23 944 | 15 052 | 9 055 | 7 241 | 8 153 | 1 831 | 65 276 |

ACT included in NSW

NT included in SA

1. Vasotomy or vasectomy
2. Salpingectomy or ligation of fallopian tubes
3. Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method.

Figures are for Medibank claims only. They do not include cases for which no claim is made, i.e. public ward patients and FPA clinics covered by health program grant.

Source: Commonwealth Department of Health.

Annexe IV. I

'Single, pregnant, what shall I do?' (Council of Social Service of NSW publication)

Single and pregnant

What shall I do?

First of all, don't panic. You are not alone. Remember that lots of people want to help you. It's best, of course, if you can talk things over with your family and the baby's father, but if you can't, there are many people who are experienced in helping women with problems like yours. There's—

- your doctor
- your priest or minister
- the social worker at your local hospital or at a family agency
- workers from Community Aid Centres

If the help you get doesn't meet your needs, try somewhere else.

There are many possibilities to consider:

- marriage
- abortion
- adoption
- keeping the baby and remaining single
- living with the baby's father
- fostering

You must consider them *all* carefully.

Whatever you do, make sure you get medical attention as early in the pregnancy as possible. This is essential for the health and well-being of you *and* your baby.

What can I live on?

If you continue with the pregnancy and do not marry, you will need financial advice.

Briefly, if during the first six months of your pregnancy you are not able to work, you will probably be able to claim Unemployment Benefit. For the last 12 weeks before the expected date of confinement, and for six weeks after the birth, you will be eligible to apply for Special Benefit. Go to the hospital social worker, the Commonwealth Employment Service or Australian Department of Social Security for help and information about these benefits.

Where shall I go?

1. Stay at home, or with a relative or friend.
2. Hostels for single mothers are run by several religious organisations, but you do not have to be a church member to go to one of these. They usually charge a percentage of your social security benefits. They may take you whether you want to keep or surrender the baby, but this varies with different hostels. There are about ten such hostels in Sydney.

3. If you are from the country, you may decide to come to the city—it is best to write to the social worker at a hospital before you come, but some of the organisations listed at the end of this pamphlet may be able to give immediate help with accommodation.

4. Go interstate? Some girls are too shy or too scared to tell their parents, and so they go off to another State. Sometimes because parents are concerned about the welfare of their daughter, or about their own position, they send her to another State.

There may be good reasons for girls to go interstate, but before you decide to go away, ask yourself—

‘Who am I really doing this for?’

‘Would it really matter if my friends knew?’

5. Take a live-in job as a mother’s help. These are advertised in newspapers, or a hospital social worker may know of positions available. Such a job can help with your financial arrangements, and may be useful to see what small children are like. But before you commit yourself to taking any position talk over the details with some helping person, and be sure you will like the family and know what the job entails.

6. You can continue in your job until quite late in your pregnancy if you are healthy. If you are still at school, stay there, or continue your education by correspondence through the Department of Education.

‘If you didn’t plan to marry before, don’t marry now’

You could get married, but remember, lots of ‘shotgun’ marriages break up. Divorces take a long, unhappy time and are expensive. The legal age for marriage for girls is 16 and for boys 18. Usually the parents’ consent is required for a person under 18. A Chamber Magistrate will be able to advise you on these matters.

Sometimes an unplanned pregnancy tells you a lot about a relationship. Ask yourself—

‘Does he really want the baby?’

‘Is he just doing the right thing?’

‘Is he planning for a family of three, or is he just drifting along hoping everything will be OK?’

and—

‘Am I ready for marriage myself or am I just thinking of it because I am in a tight corner?’

Are abortions legal?

At the present time, the law about abortion in New South Wales says, broadly, that a doctor must conscientiously believe that continuation of the pregnancy would be more harmful to the woman’s health and well-being generally than an abortion would be. At the major public hospitals, while abortions are performed, there is no automatic abortion on demand. You can obtain counselling about an unplanned pregnancy and eligibility for abortion at the Family Planning Clinic, Womens Health Centre (Leichhardt), and from Control. The Family Planning Adviser at the Australian Department of Health will give information about Adolescent Action Clinics where you may obtain advice.

What's the procedure?

Obtain a letter confirming your pregnancy, either from your GP or from a Pregnancy Testing Service. This is required because, while pregnancy is the usual reason why periods cease, there can be other reasons, and it is as well to ascertain that you are pregnant before getting an appointment at an abortion clinic.

Telephone one of the major obstetric hospitals for an appointment or call in, taking the letter with you. In most of the public hospitals in Sydney, a patient requesting abortion is seen first by a social worker, who will explore the situation with you, and discuss the whole question on a very individual basis. You are usually then seen by a doctor, and given a decision. If abortion is agreed to, most patients are admitted to hospital more or less straight away. In most of the public hospitals you will be in hospital 24 hours, which means at least one night there. However, it is possible at some hospitals to be discharged the same day.

In most cases, abortion is not possible if the patient is over 11 or 12 weeks pregnant, so if abortion is the course of action that you decide upon, it is essential that you attend very early on at a hospital or clinic.

What does it cost?

Since October 1975 people resident in New South Wales have been entitled to free public hospital accommodation and treatment according to medical need, so if you do go to a public hospital, there will be no cost to you.

There also exists in Sydney the Preterm Clinic, where abortions are carried out by qualified doctors, and where you do not have to stay in overnight. Here you would have to pay approximately \$90.00; about two-thirds would be refundable through Medibank, and if you have private health insurance you could claim a refund for the balance.

Afterwards . . .

In both the public hospitals and the Preterm Clinic, efficient contraceptive advice will be given following the abortion, and you will be asked to attend for a check-up some time after the abortion has been performed, to make sure that all is well with you medically.

Important points to consider in relation to abortion

1. It would be wise to discuss the whole question of abortion very fully with somebody other than your parents, or the baby's father; in other words, someone who is not emotionally involved in your situation.
2. It is important to remember that an abortion, if performed, should always be undertaken by fully qualified and experienced doctors, in a suitable hospital or clinic. If done in this way the risk attached to abortion is comparatively low, but serious consequences can result if an abortion is carried out either too late in pregnancy or if there is not sufficient care taken in the procedure.
3. Not everybody believes in abortions. If it is against your religion, or personal convictions, organisations like Heartline may be able to help you to come to alternative decisions.
4. If you are worried about any costs associated with an abortion, discuss this with the social workers at the Australian Department of Social Security, who will be able to advise you on financial help available.

How do I go about having my baby adopted?

There are several private adoption agencies in Sydney: you may prefer to discuss adoption with an officer from the Department of Youth, Ethnic and Community Affairs. Addresses are listed on the back of this pamphlet.

How can I be sure my baby will have good parents?

It may be helpful to talk to a social worker in an adoption agency, even if you are very undecided about your plans for the baby. If you are planning to surrender your baby for adoption you will be asked to give details of your family and the baby's father's family so that he can be placed with adopting parents from a similar background to your own.

There is a shortage of babies available for adoption and babies with medical problems, older babies and children of mixed race are now usually able to be adopted. Parents are very carefully selected, their homes are visited, and financial and social circumstances are very thoroughly investigated.

Some agencies will give you a little news of the baby after placement, and perhaps a photo if you wish, as well as giving you information about your baby's new family.

When do I sign the papers?

Not until the fifth day after the baby is born. From the day you sign, you usually have 30 days in which to change your mind, or 'revoke your consent'. You do this by notifying in writing the Family Law Court, 50 Phillip Street, Sydney, on or before the 30th day from the day on which you sign the consent. After the 30 days are up, there is no way you can change your mind, and it is not a good idea to sign adoption papers unless you are fairly sure that this is what you want for the baby.

And afterwards . . .

It is a very difficult thing to surrender a baby for adoption. Some mothers take a long while to get over their loss, and may need to talk it over with someone. The hospital social worker or the adoption agency will be anxious to help if you experience difficulties or depression afterwards. Other mothers feel very guilty at even thinking about adoption—don't feel guilty. If you are not 100 per cent convinced that you want to be a parent, adoption may be much the happiest solution for your child. Every year mothers who thought they could manage on their own are surrendering older children for adoption because they found that they weren't able, or did not want to go on coping alone.

Shall I keep the baby?

This is a very difficult decision to make, and there are many questions to ask yourself:

Will my family help me?—my friends?

Who am I thinking of—myself or my child?

Will my chances of a happy marriage be affected?

Will I be able to earn enough for the two of us?

Am I just thinking of my child only while it is a baby?

Who will look after the baby if I work?

How will keeping the baby affect my interests and social life?

Am I prepared to accept possible criticism for keeping my child?

How will I explain to my child that he hasn't a father like everyone else?

Can I be sure that adoption is best for my baby?

Some women find it easier than others to keep their children and raise them alone, but it isn't impossible. It is important, though, to be really sure that you want to, and to have someone close, family or friends, to share the task with you. You may like to talk it over with other single mothers who have kept their children, and see what kinds of problems they have and how they manage. CHUMS (Care and Help for Unmarried Mothers) is such a group of single mothers who get together for company and are a point of contact with other unmarried mothers. There are branches in several Sydney suburbs, and also in Wollongong and Moree.

The decision is yours

Whatever your age or situation, the decision is ultimately yours, because you are the baby's legal guardian. Do not allow anyone to persuade you either to keep or give up the baby. Ignore thoughtless people who condemn you for giving the baby up, those who deny any difficulties in bringing up a child alone; examine carefully the offers of help you'll receive if you're planning to keep the baby.

Can I afford to keep the baby?

1. Maternity Allowance of \$30 is available to all mothers.
2. Child Endowment is at present (October 1975) 50 cents per week for the first child. (Check these figures with the Department of Social Security.)
3. If you want to remain with your baby while it is small and do not want to work, you can ask for assistance in the first six months from the NSW Department of Youth, Ethnic and Community Affairs. However, the Department will expect you to co-operate in taking action, where possible, to try to get some assistance from the baby's father.
4. After the first six months you may be eligible for a Supporting Mother's Benefit from the Australian Department of Social Security. At present (October 1975) this is \$98.00 maximum fortnightly.
5. The social worker at the Australian Department of Social Security will advise you on other Australian Government benefits that will help you.
6. It could be hard to live on the money you get and you may feel that you would like to take a part-time job to help you out. Before you do this, it would be best to check with the Department of Youth, Ethnic and Community Affairs, or the Department of Social Security, to see what effect the extra money would have on your allowance.

What about the baby's father?

Some girls, because they are proud, or for some other reason, won't ask the father of the child for anything. No one can make them ask, but it is often the baby who suffers most. Other girls may want to hurt the baby's father and demand help which he cannot give. The father has an obligation to contribute a reasonable amount towards—

- Expenses related to your baby's birth
- Your support before and after the birth
- The maintenance of the baby if you keep it

If the baby's father does not help as he should, you should contact the nearest office of the Department of Youth, Ethnic and Community Affairs. You may dislike the idea of taking legal action against him, but remember that you will need all the help you can get if you keep the baby.

What happens if I marry later?

If you marry the child's natural father, your child will be legitimated, but you must apply to the Registrar of Births, where the child was first registered, and inform him within three months of your marriage so that a new birth certificate can be issued.

If you marry another man, it is usually advisable for the mother and husband to adopt the child jointly, so that it will have the same name and rights as other children who may be born. To do this, contact the Department of Youth, Ethnic and Community Affairs, a private solicitor or an adoption agency.

What else should I know?

If you keep the baby you need information about day nurseries (most have a long waiting list), applying for Housing Commission accommodation, making a will, and retraining schemes.

Where can I go for help?

All sorts of problems arise when you are bringing up a child on your own, from keeping him clothed to coping with him if you get ill, from wondering what to feed him and when, to deciding what to tell him about his father. Sources of help are listed on the back of this pamphlet.

Will it happen again?

Contraceptive advice is readily available to single and married women from GPs, or any of the addresses listed on the back of this pamphlet under Family Planning.

Information and Counselling Services

General

Abortion Law Reform 13 Bellevue Road, Bellevue Hill 2023. Tel. 36 6016.

Anglican Counselling Service Cnr Kippax and Waterloo Streets, Surry Hills 2010. Tel. 211 1244.

Associated Single Parents 19 George Street, Pennant Hills 2120

Australian Department of Health Australian Government Centre, Chifley Square, Sydney 2000. Tel. 232 8000.

Australian Department of Social Security 50 Carrington Street, Sydney 2000. Tel. 2 0255. See telephone book (Australian Government) for suburban and country offices.

Australian Red Cross Society 159 Clarence Street, Sydney 2000. Tel. 29 2622.

Baby Health Centres See telephone book (Other Names section).

Baptist Community Services 155 Epping Road, Marsfield 2122. Tel. 888 1600.

Birthingright 2 Albert Street, Sydney 2000. Tel. 27 2169.

Care and Help for Unmarried Mothers (CHUMS) 2nd Floor, 710 George Street, Sydney 2000. Tel. 212 3915.

Catholic Family Welfare Centacare CUSA House, 175 Elizabeth Street, Sydney 2000. Tel. 26 6873.

City Clinic Crisis Service Smith Family Building, Crown Street, East Sydney 2010. Tel. 31 7016.

Commonwealth Employment Service See telephone book (Australian Government) for offices in suburbs and country.

Community Aid Centres Suburban and country centres. Ring NSW Council of Social Service for information. Tel. 26 1946.

Control—Abortion Referral Service 25 Alberta Street, Surry Hills 2010. Tel. 61 7325.
Crisis Centre Wayside Chapel, 29 Hughes Street, Potts Point 2011. Tel. 358 1010, 358 6577.

Department of Education NSW Bridge and Loftus Streets, Sydney 2000. Tel. 2 0584.

Correspondence School 52 William Street, Sydney 2010. Tel. 31 8011.

Heartline 32 York Street, Sydney 2000. Tel. 29 1057.

Housing Commission of NSW 302 Castlereagh Street, Sydney 2000. Tel. 2 0981. See telephone book (State Government) for suburban and country offices.

Parents Without Partners PWP House, 32 Grosvenor Street, Sydney 2000. Tel. 27 2750.

Pregnancy Referral Service 25 Alberta Street, Surry Hills 2010. Tel. 61 7325.

Preterm Foundation St Anne's Hospital, 19 Marion Street, Killara 2071. Tel. 699 9211.

Salvation Army Social Services 140 Elizabeth Street, Sydney 2000. Tel. 26 1711.

Department of Youth, Ethnic and Community Affairs Central Square, 323 Castlereagh Street, Sydney 2000. Telephone 2 0982.

Legal

Australian Legal Aid Office 10th Floor, La Salle Building, Cnr King and Castlereagh Streets, Sydney 2000. Tel. 2 0323.

Chamber Magistrates See telephone book—Courts of Petty Session (State Government).

Public Solicitor 55 Market Street, Sydney 2000. Tel. 61 6581.

The Law Society of New South Wales Legal Aid Department, 3rd Floor, 170 Phillip Street, Sydney 2000. Tel. 233 4433.

Homes, Accommodation, Hospitals

Maternity Sections are attached to most of the main public hospitals. See telephone book.

Ashfield Infants' Home 17 Henry Street, Ashfield 2131. Tel. 798 6030.

Bethesda Maternity Home 80 Victoria Road, Marrickville 2204. Tel. 51 1276.

Bethesda Salvation Army Hospital 80 Victoria Road, Marrickville 2204. Tel. 51 1276.

Carramar Maternity Hostel for Single Girls 16 Boomerang Street, Turramurra 2074. Tel. 44 7026.

Chisholm (NSW Baptist Homes Trust) Admission through application to: The Social Worker, Head Office, Willandra Village, 149-153 Epping Road, Marsfield 2122. Tel. 888 1600.

Elsie Womens Refuge 72 Westmoreland Street, Glebe 2037. Tel. 660 1371.

King George V Memorial Hospital for Mothers and Babies Missenden Road, Camperdown 2050. Tel. 51 0444.

Margaret Hallstrom Home (Methodist) 19 Leichhardt Street, Leichhardt 2040. Admission through application to Lifeline. Tel. 33 4141.

Mater Misericordiae Maternity Hospital Rocklands Road, Crows Nest 2065. Tel. 929 7022.

Our Lady of Mercy Home (Roman Catholic) 33 Pacific Highway, Waitara 2077. Tel. 48 0241.

Queen Victoria Hospital for Women and Babies (Presbyterian) 61 Albion Street, Annandale 2038. Tel. 56 2651

Royal Hospital for Women Glenmore Road, Paddington 2021. Tel. 31 0344.
St Anthonys Home for Infants (Catholic) Alexandra Avenue, Croydon 2132. Tel. 747 5782.
St Margarets Hospital for Women 435 Bourke Street, Darlinghurst 2010. Tel. 31 0466.
South Sydney Womens Hospital 37 Gilpin Road, Camperdown 2050. Tel. 51 2861.
Womens Hospital Crown Street Crown Street, Darlinghurst 2010. Tel. 31 0477.

Immediate Practical Help

Lifeline Centre 58A Flinders Street, Darlinghurst 2010. Tel. 33 4141.
Department of Youth, Ethnic and Community Affairs Central Square, 323 Castlereagh Street, Sydney 2000. Telephone 2 0982.
Food for Babies Fund 18 Bridge Street, Sydney 2000. Tel. 27 4297.
St Vincent de Paul Society Ozanam House, 7 Young Street, Sydney 2000. Tel. 27 4698.
The Smith Family 137-153 Crown Street, Sydney 2000. Tel. 31 0222.

Adoption Agencies in New South Wales

Department of Youth, Ethnic and Community Affairs Central Square, 323 Castlereagh Street, Sydney 2000. Tel. 2 0982. Regional offices in suburbs and country centres. See telephone book under State Government.
Anglican Adoption Agency of New South Wales 5th Floor, Standard House, Cnr Waterloo and Kippax Street, Sydney 2000. Tel. 211 1244.
The Benevolent Society of New South Wales Adoption Agency 171 Glenmore Road, Paddington 2021. Tel. 33 4141.
Catholic Adoption Agency of New South Wales Ozanam House, 7 Young Street, Sydney 2000. Tel. 27 7875.
Presbyterian Adoption Agency of New South Wales 44 Margaret Street, Sydney 2000. Tel. 29 2954.
Seventh Day Adventist Adoption Agency 84 The Boulevarde, Strathfield 2135. Tel. 747 5655.
Sydney Rescue Work Society 2nd Floor, KRA-MAR House, 23 Belmore Street, Burwood 2134. Tel. 745 1855.

Family Planning

Family Planning Association 92 City Road, Chippendale 2008. Tel. 698 9499.
Family Planning (Catholic) 245 Broadway, Sydney 2000. Tel. 660 1144.
Leichhardt Womens Community Health Centre 164 Flood Street, Leichhardt 2040. Tel. 56 6401.

Country

Goulburn

Family Welfare Bureau Sts Peter and Paul Presbytery, 36 Verner Street (P.O. Box 11), Goulburn 2580. Tel. 21 1022.

Maitland

Villa Maria (Catholic) 50 King Street, East Maitland 2323. Admission through Catholic Family Welfare, 12 Tudor Street, Hamilton, 2303, Tel. 69 2199; or The Social Worker, Mater Misericordiae Hospital, Waratah, 2295, Tel. 68 0455.

Newcastle

Birthright P.O. Box 270, Newcastle 2300. Tel. 61 5204

Pregnancy Help Centre (Right to Life Assoc.) 1st Floor, Manchester Unity Building, 560 Hunter Street, Newcastle West 2302. Tel. 2 5702.

Annexe IV.J

Table IV.J.1 Services provided by Pregnancy Support Services

| | Can- berra | New- castle | Bris- bane | Adel- aide | Sydney | Mel- bourne* |
|--|---------------|----------------|---------------|---------------|--------|-----------------|
| Telephone counselling 8 hours each weekday | * | | * | * | | |
| Telephone counselling less than 8 hours each weekday | | * | | | * | * |
| In-office counselling— medical | * | | | * | | |
| In-office counselling— social | * | | * | * | * | * |
| Financial assistance | | | * | * | | |
| Referral to medical/social services | * | * | * | * | * | * |
| Transportation assistance | * | * | * | * | * | * |
| Home help | * | * | * | * | * | * |
| Baby-sitting | * | | * | * | * | * |
| Help finding— housing | * | | * | * | * | * |
| live-in jobs | * | | * | * | * | * |
| Clothing and furniture pool | | | * | * | * | * |
| Post-partum counselling | * | * | * | * | * | |
| Number of locations | 1 | 1 | 1 | 1 | 2 | 1 |

* The information in all tables is from a questionnaire that was sent to Pregnancy Support Services. Two services—Melbourne and Townsville—did not reply. The information for Melbourne is extracted from their submission, so is not necessarily complete.

Table IV.J.2 Telephone calls and visits to Pregnancy Support Services, 1973–75

| | Telephone calls | | | Visits | | |
|------------------------------|----------------------|-------|-------|----------------------------|------|------|
| | 1973 | 1974 | 1975 | 1973 | 1974 | 1975 |
| Canberra (Opened Aug. 1974) | .. | 30 | 73 | .. | 4 | 6 |
| Newcastle (Opened Nov. 1974) | .. | 5 | 89 | telephone counselling only | | |
| Brisbane (Opened June 1973) | 225 | 888 | 2 283 | 121 | 433 | 721 |
| Adelaide | 900 | 1 200 | 1 500 | 126 | 160 | 210 |
| Sydney | Opened February 1976 | | | | | |
| Melbourne | | | | | | |
| | 708 | | | | | |

Table IV.J.3 Personnel of Pregnancy Support Services**Paid:**

Brisbane: 1 part-time social worker

Adelaide: 1 part-time in-office counsellor

1 part-time social worker

Voluntary:

| | Canberra | Newcastle | Brisbane | Adelaide | Sydney |
|-------------------------------|----------|-----------|----------|----------|--------|
| Doctor— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | 2 | .. | 6 | 2 | .. |
| Nurse— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | .. | .. | 4 | 2 | .. |
| Telephone counsellors— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | 32 | 31 | 30 | 15 | 15 |
| In-office counsellors— | | | | | |
| Full-time | .. | .. | 1 | .. | .. |
| Part-time | 4 | .. | .. | 2 | .. |
| Social workers— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | 4 | .. | .. | 2 | 1 |
| Psychologists— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | .. | .. | .. | 1 | .. |
| Field officers— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | 5 | .. | 30 | .. | .. |
| Community education officers— | | | | | |
| Full-time | .. | .. | .. | .. | .. |
| Part-time | .. | .. | .. | 2 | .. |

Table IV.J.4 Financial resources of Pregnancy Support Services

| | Canberra | Newcastle | Brisbane | Adelaide | Sydney |
|--|----------|-----------|----------|----------|-------------------------|
| Government ongoing funding | | | * | | |
| Once only government grant | | | | | * |
| Funding from private organisation | | | | | NSW Right to Life |
| Donations from private organisations and individuals | * | * | * | * | * |

All associations except Sydney have some fund-raising activities such as raffles, subscription drives and bring and buy sales.

Annexe IV.K

Abortion laws in the United States and New Zealand

(i) *The United States*

Because of its differing constitutional basis, the United States law with respect to abortion does not have a direct bearing on the Australian situation. It does have some relevance, however, because the US Supreme Court ruling in *Roe v. Wade* of January 1973 (93 S Ct 705 1973) reviewed the common law history which both jurisdictions have in common, and the recent New Zealand case of *R. v. Woolnough* reviewed the US decisions.

In 1973 the US Supreme Court held that the constitutional right to privacy was broad enough to encompass a woman's decision whether or not to terminate her pregnancy. It held that the state has an overriding and compelling interest in protecting the health of the pregnant woman, but that this does not come into existence until the end of the first trimester (12th week of pregnancy) and that, even then, the state may only regulate abortion procedure so far as the regulations relate to the preservation and protection of the woman's life and health. The state also has an interest in protecting the potentiality of human life but only when the life becomes 'viable' and even then the life or health of the mother is to remain paramount. The court also held that the word 'person' as used in the fourteenth Amendment does not apply to the unborn.

Since 1973 the law has remained basically unchanged. In July 1976 the Supreme Court ruled that state laws requiring a married woman to get her husband's consent, or a minor to have her parents' or guardian's consent, to obtain a first trimester abortion were unconstitutional. (*Planned Parenthood of Central Missouri v. Danford*, US Supreme Court no. 74-1151 (1976)). Laws which require, however, that a physician exercise as much skill and care to 'preserve the life and health' of a viable foetus as of a child naturally born alive have been upheld (same case as above).

Constitutional attempts have been made to reverse the impact of the 1973 US Supreme Court decision by (1) an amendment which would delegate to the states the right to regulate abortion; and (2) an amendment which would define 'person' in the constitution as meaning 'all human beings, including their unborn offspring at every stage of their biological development, irrespective of age, health, function or condition of dependency'. Attempts have also been made to have abortion taken off medicare (i.e. the national health service) except for abortions performed for 'medical' reasons, and to restrict the availability of abortion by court proceedings such as the conviction of Dr Kenneth Edelin in Boston in 1975 for manslaughter of a foetus claimed to be viable.

(ii) *New Zealand*

Of more direct bearing on the Australian situation is the recent interpretation given to the New Zealand law in the case of *R. v. Woolnough*. In April 1976, Dr James Woolnough was acquitted by the Supreme Court of Auckland of unlawfully using a suction curette with intent to procure a miscarriage. The case rested on the interpretation of section 183 of the New Zealand Criminal Code, which reads:

- (1) Everyone is liable to imprisonment for a term not exceeding 14 years who, with intent to procure a miscarriage of any woman or girl, whether she is with child or not,

- (a) unlawfully administers to or causes to be taken by her any poison or any drug or noxious thing
 - (b) unlawfully uses on her any instrument
- (2) The woman or girl shall not be charged as a party to an offence against this section.

Mr Justice Chilwell said that:

Although this crime has been expressed in statutory form for a very long time, the legislature for some reason has never taken the trouble to state in positive terms what is lawful and what is unlawful. It has been left to the courts in Britain, New Zealand and the Commonwealth generally to place an interpretation upon the word 'unlawfully' . . . the test of whether or not the use of the instrument is unlawful is whether it is necessary to preserve the woman from serious danger to her life or to her physical or mental health, not being the normal dangers of pregnancy and childbirth.

The New Zealand Court of Criminal Appeal in July of the same year upheld the decision of Chilwell J. relying on two decisions, one of the British Court of Criminal Appeal and one previous New Zealand decision.

The British case *R. v. Newton and Stungo* (1958) (Crim. L R 469) contained the statement of Ashworth J.:

Use of an instrument is unlawful unless this use is made in good faith for the purpose of preserving the life or health of the woman. When I say health I mean not only her physical health but also her mental health.

The New Zealand case *R. v. Anderson* (1951) (NZLR 439 at 443) was regarded by the Appeal Court as supporting their decision that *R. v. Bourne* applied to New Zealand. The Appeal Court held that as there were no legislative guidelines for construing the meaning of 'unlawful' the test used by Chilwell J., based on these authorities, should be approved.

The New Zealand Supreme Court has also ruled that the 1975 Hospital Amendment Act, which prohibited abortions to be done in clinics, is invalid.

Annexe IV. L

Description of foetal development

(i) *General description of foetal development by Prof. A. W. Liley (from Submission 162, National Right to Life Association)*

One hour after the sperm has penetrated the ovum, the nuclei of the two cells have fused and the genetic instructions from one parent have met the complementary instructions from the other parent to establish the whole design, the inheritance of a new person.

The one cell divides into two, the two into four and so on, while over a span of 7 or 8 days this ball of cells traverses the fallopian tube to reach the uterus.

On reaching the uterus, this young individual implants in the spongy lining, and, with a display of physiological power, suppresses his mother's menstrual period. This is his home for the next 270 days, and to make it habitable the embryo develops a placenta and a protective capsule of fluid for himself.

By 25 days the developing heart starts beating, the first strokes of a pump which will make 3000 million beats in a lifetime.

By 30 days and just 2 weeks past the mother's first missed period, the baby, one-quarter inch long, has a brain of unmistakable human proportions, eyes, ears, mouth, kidneys, liver and umbilical cord and a heart pumping blood he has made himself.

By 45 days, about the time of mother's second missed period, the baby's skeleton is complete, in cartilage not bone, the buds of the milk teeth appear and he makes the first movements of his limbs and body—although it will be another 12 weeks before mother notices movements. By 63 days he will grasp an object placed in his palm and can make a fist.

Most of our studies of foetal behaviour have been made later in pregnancy, partly because we lack techniques of investigation earlier and partly because it is only the exigencies of late pregnancy which provide us with opportunities to invade the privacy of the foetus.

(ii) *Source: Submission 162, NRTL*

The history of a human being

Human nature is independent of legal status, which assigns and retracts certain rights and responsibilities at sequential stages of development of the social human being. Protection is afforded when needed, and retracted when no longer needed, rights and responsibilities transferred from parent to offspring at an age when assumed maturity would dictate. Life is a continuum from conception to death. For many purposes it has been found convenient, in the manner of scientific procedure, to impose upon this continuum an artificial discontinuity. We assign names to stages of development of a living thing to demark points in the progress of its development. Thus in humans we distinguish:

A. The zygote

This is the fertilised ovum, now constituting a different type of being from the *gametes* from which it was formed. These gametes, the female *ovum* and the male *spermatozoon* respectively, bear in their *chromosomes*, and the component *genes* of the chromosomes, the genetic character of the person from whom they derive. The ovum is produced from the woman's body. All cells of her body contain a specific set of 46 chromosomes and of component genes which imprint the physical characteristics determining her physical make-up. Not all genes operate in all cells, but all are there. *In general*, the chromosomes occur as 22 pairs of autosomes and 2 sex chromosomes. Her gamete, the ovum, is different from other cells of the body in containing only one from each pair of the 22 pairs of autosomes, and one sex chromosome, which is always an X, or female-determining chromosome, for both sex chromosomes are

alike in the female. Thus the ovum contains only 23 chromosomes, half the number in other cells, but representative of the woman's whole genetic make-up. The male gamete, the spermatozoon, contains in its head one from each pair of the man's 22 pairs of autosomes and again one sex chromosome, which may be an X or Y chromosome, that is a male-or female-determining one. The sex of the new human being resulting from union of spermatozoon and ovum is thus determined by the man's contribution. If there are two X or female-determining chromosomes, the sex of the new human being will be female. If an X and a Y chromosome are present, the sex will be male.

The destiny of the ovum is to be fertilised, that of the spermatozoon to fertilise. If this union does not occur, having no other function they die within a short time. If fertilisation does occur, the zygote produced is fundamentally different from the gametes from whose union it resulted. It is different in *make-up* and in *destiny*.

It has the full complement of chromosomes, 23 pairs, but one of each pair was contributed from each parent. Its genetic make-up is not that of either father or mother, but a new genetic make-up, in all probability unique in human history, so vast is the number of permutations of options from combination of two sets, each of some tens of thousands of genes.

The zygote has a different destiny. Aside from accidents, it will now proceed to become a mature member of the human species. The single cell that the zygote is will divide in two, these two will divide into four, and so on, under internal direction. The cells formed by this continuing multiplication will be directed by the zygote to differentiate, to take on specific forms and functions and so to form structures and organs which will constitute the complete, autonomous adult that will derive from this autonomous beginning. The only additions to it, until it dies, at whatever age or stage of development, will be food, oxygen and water. It will direct the pregnancy until its own hormonal signal brings about its birth. The mother's function will be to supply unconsciously its material needs and shelter for its secure development.

B. *The embryo*

Differentiation is marked by this new name. It is well into progress by the time the hollow ball of cells, the *blastocyst*, arrives on the wall of the womb, prepared to receive it by hormonal signals generated at conception. Constituted by internal direction from the genetic material and deriving its raw material from the fluids bathing the membranes it has traversed, it bears within it the embryonic disc, two layers of different cell types, the endoderm and the ectoderm. From the ectoderm will develop the skin and its glands, the sense organs and the nervous system. The endoderm will form the hollow digestive tract, respiratory and urinary systems. The other tissues come from a third layer, formed a few days later, the mesoderm.

The lower layer of cells of the blastocyst, the *trophoblast* ('seeking cells') moves out and digests its way into the lining of the womb, seeking nourishment from the congested vessels whose formation is part of the preparation of the womb for this implantation. This marks the beginning of the *placenta* from which the baby will receive nourishment. Here its blood system will come into close proximity with the mother's, allowing an interchange of oxygen and food in one direction and waste products in the other. They are two separate blood systems and there is no direct mixing. Such mixing if permitted could be disastrous for both mother and baby as their bloods could be different groups. Indeed, the difference in genetic make-up of mother and baby raises the question of why there is not rejection, as usually tends to occur in organ transplantation from another individual. The answer is that this rejection mechanism is suppressed by the action of the trophoblast. 'Pregnancy can be regarded as a graft-host relationship' says a recent article.¹ 'It is an unusual one in

1. A. E. Beer & R. E. Billingham, 'The embryo as transplant', *Scientific American* 230, 4 (1974), p. 36.

that the embryo seems to be indifferent to the maternal immune response. Trophoblast cells are uniquely refractory to transplantation immunity.² Sir William Liley refers to this as a 'dazzling feat by which foetus and mother, although immunological foreigners who could not exchange skin grafts nor safely receive blood from each other, nevertheless tolerate each other in parabiosis for nine months'.³ Sir William Liley is one of the world's leading foetologists and has been called 'the father of foetology'.

Early development is very rapid. 'By 25 days the developing heart starts beating, the first strokes of a pump which will make 3000 million beats in a lifetime. By 30 days and just two weeks past mother's first missed period the baby, ¼in. long, has a brain of unmistakable human proportions, eyes, ears, mouth, kidneys, liver and umbilical cord and a heart pumping blood he has made himself.'⁴

Six and a half weeks after conception, we have a beginning of movement, the milk tooth buds appear and the skeleton of cartilage is complete.⁵ The baby's mother has just missed her second period.

C. *The foetus*

At 8 weeks from conception the baby is complete. All the primordia or primitive organs are now present and will shortly be in operation. From here until birth we have now only growth, no more development, no other organs or structures will be added until this hidden, early development of man is complete.

D. *The infant*

After birth there is no great physiological change except that air is now breathed and food is given by mouth. The environmental change is abrupt and the baby is now reliant on others for food and care, less independent than before birth. It now begins the processes of physical, mental and social learning that will equip it for independent life. Its development in the true biological sense can be said to be nearly over. 'Of the 45 generations of cell division needed to get from the fertilised ovum to the adult, 41 divisions have occurred by the time we are born and the final tedious four occupy childhood and adolescence.'⁶

2. *ibid.*, p. 46.

3. A. W. Liley, 'A case against abortion', *Liberal Studies Broadsheet* 4 (Whitcombe & Tombs, NZ, Aust., London), p.2.

4. *ibid.*

5. *ibid.*

6. *ibid.*

Annexe IV.M

Methods of abortion

Main methods currently in use in Australia

Definitions of these various methods appear at Annexe IV.C.

Early termination: vaginal methods

Menstrual extraction—menstrual regulation

This procedure is carried out before diagnosis of pregnancy (at the time the period is due or 2 weeks later). The technique is the same as vacuum aspiration.

Dilatation and curettage

Performed up to 12 weeks pregnancy.

The cervix, or lower portion of the uterus, is dilated with a series of instruments of gradually increasing size to allow the insertion of a curette, or scraping instrument. The products of pregnancy are scraped from the uterine wall. It can be done under a local anaesthetic which is injected alongside the cervix.

General anaesthetic is most commonly used. Now being superseded by vacuum aspiration.

Vacuum aspiration—suction aspiration—vacuum curettage

Performed up to 12 weeks, the cervix is dilated as in a D & C to allow the insertion of an aspirator which removes the contents of the uterus by vacuum suction. Since the aspirator is of narrow gauge, less dilation is needed and a local anaesthetic may be used or even no anaesthetic in early pregnancy. This is the most common method in the first trimester.

Mid-term termination

Hysterotomy

May be performed at any time. The contents of the pregnant uterus are removed through an incision in the uterine wall. This is an inpatient procedure done under general anaesthetic. It is now used less.

Hysterectomy

The uterus and its contents are removed by an abdominal operation under general anaesthetic. This is an inpatient procedure.

Late termination

Saline induction

This method is used only after the 16th week, often in cases of late diagnosis of foetal abnormality. A needle is inserted through the abdominal wall and removes some fluid from the amniotic sac in which the foetus is contained. Saline solution is injected into the sac. This kills the foetus and brings on labour 24–36 hours later. The procedure is done under local anaesthetic, and 2 to 3 days hospitalisation is necessary.

Prostaglandin induction

This is a relatively new method, carried out from 16th to 20th week. The prostaglandins are injected into the amniotic sac and induce labour. The death of the foetus may occur in labour but in some cases it is born alive.

Annexe IV.N

Table of patients known to have had abortion

| Area | Figures for last 6 months preceding reply |
|--------------------------------|---|
| Metropolitan | 21 530 (91 per cent of those consulting) |
| Country | 7 420 (82 per cent of those consulting) |
| Area not known weighted by 4.5 | 250 |
| Total for 6 months | 29 200 (approximately) |
| Total for year | 58 400 |

Source: Survey of medical practitioners, 1976, Commission research report, no. 1 (at Annexe III.A).

The figures obtained are rough estimates only, as they are derived from sample replies, weighted according to area of practice. That is, it was assumed that the experience of the other four-fifths or three-quarters of doctors (according to stratum) was the same as regards the number of women known to have had their pregnancies terminated in the last 6 months. Results are summarised in the table.

A further description of the methodology used to obtain these figures is available in the description of the medical education survey, research report no. 1 (at Annexe III.A).

Annexe IV.O

'Demographic aspects of abortion', an abridgment of a paper written for the Commission by Dr L. T. Ruzicka, Australian National University, August 1976

Legally induced abortions in South Australia: demographic characteristics

Three important variables must be taken into consideration when examining the incidence of abortions: the marital status of the women, their age and their family size. The annual statistics of abortions performed under the South Australian law provide information on the first and the second, but only for 1971 on the third characteristic. Table IV.O.2 contains the basic data for the period 1970-74.

The number of abortions has been rising from the low 1330 in 1970 to 2852 terminations in 1974. The low figure for 1970 is more likely to indicate that when the new law became operative women, when pregnant, either did not know about or hesitated to take advantage of the possibility of having their pregnancy terminated even if they wished to, rather than reflecting the true demand for pregnancy interruptions. The age-specific rates in table IV.O.3 appear to suggest that this was particularly the case among the younger women, most of whom might have been single.

The age-specific abortion rates increased between 1970 and 1971, particularly at ages below 25 years, but since 1971 have remained relatively stable but for the age group 16-19 years. At those ages the rates increased slightly between 1971 and 1973 but appeared to be marginally declining in 1974.

The peak of the age-specific abortion rates since 1972 has remained at the ages 16-19 years, with a high level maintained though the ages 20-24 years.

Most abortions were described as having been performed for 'specific psychiatric disorders'; the percentage of such indications increased from 83.9 in 1970 to 91.3 in 1974 while the indications labelled 'specific medical disorders' receded in importance by about the same proportion, from 10.4 per cent in 1970 to 4.9 per cent in 1974. This pattern is common to all countries where abortion is permitted on grounds of the physical as well as the mental health of the mother being in danger if pregnancy were carried to term. Under such circumstances it is impossible to determine to what extent social problems manifest themselves as 'psychological indicators' for the termination of pregnancy.

One of the most important differentials in the incidence of abortion is that by marital status. The statistics available for South Australia do not provide tabulations by age and marital status. We can, however, assess indirectly the relevance of marital status for the incidence of abortions. Assuming that the age-specific abortion rates were the same for women of each marital status category, we may obtain an 'expected' number of abortions for women of a given marital status and then compare the actual 'observed' number with the 'expected' one. If the ratio between 'observed' and 'expected' numbers of abortions significantly exceed unity, that marital status category would have a higher incidence of abortions than the whole population, and vice versa. The results of such calculations are in table IV.O.4, for the periods 1971-72 and 1973-74. In all instances the differential incidence of abortions is statistically significant at the 5 per cent level of significance or lower. The results for both periods under consideration are consistent.

The single women had an incidence of abortions 26-31 per cent above the average for all South Australian women while for the married women the incidence was 30-31 per cent below that average. Divorced and separated women had four times more abortions than would be expected if the incidence were the same as for all women irrespective of marital status.

It appears that the widowed women may have a somewhat higher than average number of abortions; however, because of the small numbers (28 abortions expected and 42 and 54 recorded respectively in 1971–72 and 1973–74) it is not possible to attach too much importance to the ratios 1.5 and 1.9 shown in table IV.O.4.

It seems that contraception has a less significant role amongst the unmarried. Contraceptive advice and facilities were, until recently, denied to unmarried women or not easily available for a variety of reasons, some of them clearly personal (embarrassment while asking for prescription) and some reflecting society's attitude towards pre-marital and non-marital sex.

Peel and Potts (1969), commenting on similar findings in Britain, expressed a view that seems to have validity in Australia as well. They wrote: 'Thus, whilst contraceptive failure may be a legitimate reason why married women seek abortion, single women are more likely to experience an unwanted pregnancy as a result of contraceptive non-use.'

Rather than relating abortions to the number of women of a given age, it is preferable to express the incidence of abortions as a proportion of all recorded pregnancies (that is abortions + confinements resulting in live birth) by women's age and marital status, and, if data are available, by the woman's parity.

Such data are presented in table IV.O.5 by women's marital status for 1970–74 and in table IV.O.6 by age (irrespective of marital status).¹ Disregarding the figures for 1970, the overall pattern is stable and consistent: about 5 and more recently close to 6 per cent of all recorded pregnancies among married women, but close to one-half of such pregnancies of non-married women, were terminated by abortion.

From table IV.O.6 it follows that at least one-quarter of recorded pregnancies at the ages below 20 years are unwanted and—if the possibility exists—are terminated by induced abortion. As might be expected, the ratios are very low at ages 20–29 years and start rising rapidly thereafter. At these ages the termination of unwanted pregnancies probably represents a mix of marital pregnancies of higher parity (abortion being a substitute for contraception or a remedy for contraceptive failure) and of non-marital pregnancies, particularly of divorced and separated women. In all, about one out of eight recorded pregnancies was terminated by induced abortion, but this increased to about one out of two if the woman was at least 40 years of age and one out of four if aged less than 20 years or between 35 and 39 years of age.

The slight increase in the proportion of all pregnancies terminated by induced abortion between 1971—the first year for which data appear to reflect plausibly the demand for terminations of unwanted pregnancies—and 1974—the latest data available—is shown in figure IV.O.1. For the purpose of a more accurate comparison between the number of pregnancies carried to term and those interrupted by abortion, the ages of women were reduced to the estimated age at conception. This allows for the different duration of pregnancy in each of the two categories: about 9 months in the former and less than 3 months in the latter. The technique used here is one suggested by Keyfitz and applied by Tietze and Dawson (1973).

From figure IV.O.1 and table IV.O.6 it appears that the age of women plays an important role in the decision to carry the pregnancy to term or have it interrupted. The proportion of pregnancies terminated by abortion is higher at the youngest and at the oldest ages of the reproductive life span than at any other age between the two extremes. Another close association may be expected to exist between such decisions and the existing number of children. If the purpose of birth control by abortion is to limit family size rather than to space births, one may expect an increased incidence of abortions among women of higher parities. Cross-tabulations of abortions by the

1. The cross-classification of women by age and marital status was not available for terminations of pregnancy by abortion.

women's age and number of existing children were available for South Australia for 1971 only.² Unfortunately, the data were not subdivided by marital status of women. To be able to relate induced abortions to the number of recorded pregnancies (confinements resulting in live birth + induced abortions) we assumed that all non-married women were childless, that is of zero parity. This assumption is clearly not fully justified but in the absence of actual evidence any alternative distribution of the ex-nuptial confinements by mother's parity would necessarily be arbitrary and even more likely to deviate from reality. In table IV.O.7 the proportions of recorded pregnancies terminated by abortion are given for women of parities zero to four and higher by approximate ages at confinement, again estimated by the de-ageing procedure referred to earlier.

On the average, 10 per cent of all pregnancies were terminated by abortion in South Australia in 1971. The rate was slightly more, 11.5 per cent, if the woman was childless; but this was mainly due to the high proportion of ex-nuptial pregnancies assigned to this parity. The percentage of pregnancies terminated by abortion dropped to 2.4 per cent for women with one living child and rose to 9.8 per cent for women with two surviving children. With the increasing number of existing children the percentage of induced abortions rose steeply and reached 23.6 per cent for women with four and more children. An identical pattern, though at different levels, was found for women of all age groups.³ As figure IV.O.2 shows, the likelihood that a woman will decide to have an unwanted pregnancy terminated by abortion is a function of both age and parity. With increasing age, the chances are greater that even lower parity women will opt for interruption of the unwanted pregnancy than their younger counterparts.

The data presented in table IV.O.2 show that about 84 per cent of women whose pregnancies were terminated in 1971-74 by induced abortion were residents of Adelaide. This proportion is higher than may have been expected from the distribution of the population. Out of all women aged 15-49 years enumerated in the 1971 census only 73.8 per cent were residents of the Adelaide statistical division, and even that included some population residing in the surrounding country areas not classified as urban.⁴ Two explanations are possible: some women from other urban and rural areas might have preferred to have the unwanted pregnancy terminated in Adelaide rather than in their usual place of residence. If that were so, the city-country comparisons of incidence of abortion are meaningless as the indices would be spurious. This would, however, not invalidate the indices and conclusions drawn from them in the preceding sections of this paper. On the other hand, it is possible that some abortions recorded in South Australia were to women from other States. If such were the case and if the numbers were considerable, that would invalidate the analysis. Since 1971 it has become increasingly easier to procure a termination of unwanted pregnancy in New South Wales and, presumably, in Victoria as well, than ever before. All the data presented here show a remarkable stability and consistency that could not be expected if during the four years 1971-74 the population 'at risk' contained a considerable and varying proportion of women non-resident in the State. On both accounts it is deemed justifiable to accept the results of the analysis as truly reflecting the incidence of induced abortions in South Australia.

2. *United Nations Demographic Yearbook 1974* (UN, 1975).

3. The percentages in brackets () in table IV.O.7 are based on less than twenty pregnancies terminated by abortion in a specified age-parity category. Because of the small number of abortions those percentages may be subject to a considerable random error.

4. The classification used by the statistician compiling the abortion data is not very clear on the point of residence of the women. The term 'city' is used in contrast to 'country', the former term presumably referring to the metropolitan city of Adelaide, the latter to all other areas, urban as well as rural.

Table IV.O.1 Estimates of the incidence of abortions in Australia based on evidence from other countries

| Country and year for which abortion rates and ratios were available | Estimated number of abortions (in 000s) based on rates or ratios related to | | |
|---|---|---|-------|
| | age distribution of female population of Australia, 1974 | age of mothers at all confinements, Australia, 1973 | |
| (1) | (2) | (3) | (4) |
| Hungary | 1972 | 236.4 | |
| | 1970 | | 375.3 |
| New York City | 1970-71 | 125.6 | 124.3 |
| Czechoslovakia | 1971 | 95.5 | |
| | 1969 | | 140.4 |
| Japan | 1971 | 83.5 | |
| | 1970 | | 116.0 |
| Finland | 1970 | 44.2 | |
| | 1969 | | 28.6 |
| Sweden | 1971 | 37.1 | |
| | 1970 | | 35.4 |
| England and Wales (residents) | 1971 | 30.2 | |
| | 1970 | | 22.1 |
| Denmark | 1969 | 23.0 | 27.1 |
| South Australia | 1974 | 30.8 | 37.1 |

Table IV.O.2 Induced abortions in South Australia, 1970-74

| | 1970 ^(a) | 1971 ^(a) | 1972 | 1973 | 1974 |
|---------------------------------|---------------------|---------------------|-------|-------|-------|
| Number of abortions | 1 330 | 2 519 | 2 672 | 2 833 | 2 852 |
| Age (in years) | | | | | |
| under 16 | 15 | 70 | 76 | 125 | 89 |
| 16-19 | 185 | 593 | 670 | 743 | 717 |
| 20-24 | 329 | 704 | 665 | 686 | 744 |
| 25-29 | 218 | 356 | 459 | 483 | 490 |
| 30-34 | 204 | 305 | 329 | 348 | 353 |
| 35-39 | 181 | 280 | 269 | 255 | 260 |
| 40-44 | 122 | 147 | 160 | 145 | 151 |
| 45 and over | 22 | 12 | 24 | 17 | 18 |
| not stated | 54 | 52 | 21 | 31 | 30 |
| Marital status | | | | | |
| single | 510 | 1 243 | 1 259 | 1 392 | 1 408 |
| married | 704 | 1 035 | 1 112 | 1 158 | 1 149 |
| widowed | 18 | 19 | 23 | 29 | 25 |
| divorced and separated | 96 | 222 | 278 | 254 | 270 |
| not stated | 2 | .. | .. | .. | .. |
| Residence | | | | | |
| city | 1 058 | 2 122 | 2 229 | 2 366 | 2 399 |
| country | 256 | 371 | 426 | 448 | 336 |
| other | 16 | 26 | 17 | 19 | 17 |
| Reason for abortion | | | | | |
| specific medical disorders | 138 | 179 | 193 | 162 | 141 |
| potential damage to foetus | 65 | 100 | 98 | 119 | 101 |
| assault on person | 11 | 16 | 13 | 10 | 5 |
| specified psychiatric disorders | 1 116 | 2 224 | 2 368 | 2 542 | 2 605 |

(a) A period from 8 January 1970 to 7 January 1971 and from 8 January 1971 to 31 December 1971.

Table IV.O.3 Age-specific abortion rates, South Australia, 1970-74

| Age (years) | 1970 | 1971 | 1972 | 1973 | 1973-74 annual average | |
|--|------|------|------|------|------------------------------|---------|
| | | | | | 1974 | average |
| Induced abortions per 1000 women of given age ^(a) | | | | | | |
| 13-15 ^(b) | 0.5 | 2.1 | 2.2 | 3.6 | 2.5 | 3.1 |
| 16-19 | 4.6 | 14.6 | 15.8 | 17.3 | 16.3 | 16.8 |
| 20-24 | 7.1 | 14.6 | 13.7 | 13.8 | 14.7 | 14.3 |
| 25-29 | 6.0 | 9.2 | 10.8 | 10.7 | 10.3 | 10.5 |
| 30-34 | 6.3 | 9.1 | 9.5 | 9.7 | 9.5 | 9.6 |
| 35-39 | 5.8 | 8.8 | 8.3 | 7.8 | 7.7 | 7.8 |
| 40-44 | 3.6 | 4.2 | 4.7 | 4.3 | 4.6 | 4.5 |
| 45-49 ^(c) | 0.6 | 0.3 | 0.7 | 0.5 | 0.5 | 0.5 |

(a) Abortions to women of not stated age were proportionately distributed to the other age categories.

(b) Abortions to women under the age 16 years per 1000 women aged 13-15 years.

(c) Abortions to women aged 45 years and over per 1000 women aged 45-49 years.

Table IV.O.4 Incidence of abortions by marital status of women, South Australia, 1971-72 and 1973-74

| Marital status | 1971-72 | | | 1973-74 | | |
|------------------------|---------------------|----------|--------------|---------------------|----------|--------------|
| | Number of abortions | | Ratio R/E | Number of abortions | | Ratio R/E |
| | recorded | expected | | recorded | expected | |
| Married | 2 147 | 3 123 | 0.69 | 2 307 | 3 306 | 0.70 |
| Single | 2 502 | 1 910 | 1.31 | 2 800 | 2 224 | 1.26 |
| Widowed | 42 | 28 | 1.50 | 54 | 28 | 1.89 |
| Divorced and separated | 500 | 120 | 4.17 | 524 | 127 | 4.13 |

The 'expected' number of abortions in each marital status category was obtained by applying the age-specific abortion rates in table IV.O.3 to the age distribution of women by marital status as on 30 June of each given year.

Tables IV.O.5 Proportion of recorded pregnancies terminated by legal abortion by marital status of women, South Australia, 1970-74

| Marital status | Recorded events | 1970 | 1971 | 1972 | 1973 | 1974 |
|--|---------------------------------------|--------|--------|--------|--------|--------|
| Married | Confinements resulting in live births | 20 679 | 20 993 | 19 860 | 18 434 | 18 119 |
| | Legally induced abortions | 704 | 1 035 | 1 112 | 1 158 | 1 149 |
| | Total pregnancies | 21 383 | 22 028 | 20 972 | 19 692 | 19 268 |
| | Abortions per 100 pregnancies | 3.3 | 4.7 | 5.3 | 5.9 | 6.0 |
| Not married (single, widowed, separated, divorced) | Confinements resulting in live births | 1 697 | 1 771 | 1 791 | 1 783 | 1 863 |
| | Legally induced abortions | 624 | 1 484 | 1 560 | 1 675 | 1 703 |
| | Total pregnancies | 2 321 | 3 255 | 3 351 | 3 458 | 3 566 |
| | Abortions per 100 pregnancies | 26.5 | 45.6 | 45.6 | 48.4 | 47.8 |

Table IV.O.6 Proportion (in per cent) of recorded pregnancies terminated by legal abortion by woman's age, South Australia, 1970-74

| Year | Age | | | | | | | Total |
|------|----------|-------|-------|-------|-------|-------|-------------------|-------|
| | under 20 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45 ^(a) | |
| 1970 | 7.9 | 3.8 | 3.0 | 6.3 | 12.6 | 24.8 | 50.0 | 5.4 |
| 1971 | 21.1 | 7.4 | 4.7 | 9.5 | 18.9 | 32.3 | 37.5 | 9.7 |
| 1972 | 23.9 | 7.7 | 5.8 | 10.9 | 22.7 | 38.5 | 55.8 | 11.0 |
| 1973 | 27.3 | 8.4 | 6.5 | 12.8 | 22.8 | 44.1 | 44.7 | 12.3 |
| 1974 | 26.5 | 9.4 | 6.3 | 12.7 | 26.9 | 45.2 | 69.2 | 12.5 |

(a) Total includes cases of not stated age.

Table IV.O.7 Abortions per 1000 conceptions by women's ages at conception and parity, South Australia, 1971

| Parity | Estimated age at conception | | | | | | Total |
|--------|-----------------------------|-------|-------|-------|-------|-------------|-------|
| | under 20 | 20-24 | 25-29 | 30-34 | 35-39 | 40 and over | |
| 0 | 181 | 93 | 49 | 73 | (69) | (123) | 115 |
| 1 | 30 | 26 | 14 | (15) | (93) | (205) | 24 |
| 2 | (68) | 88 | 62 | 115 | 204 | 463 | 98 |
| 3 | .. | 136 | 112 | 154 | 266 | 482 | 175 |
| 4+ | (1 000) | 271 | 183 | 167 | 276 | 366 | 236 |
| Total | 155 | 74 | 51 | 107 | 211 | 361 | 100 |

Indices in brackets are derived from less than 20 abortions in the age-parity category.

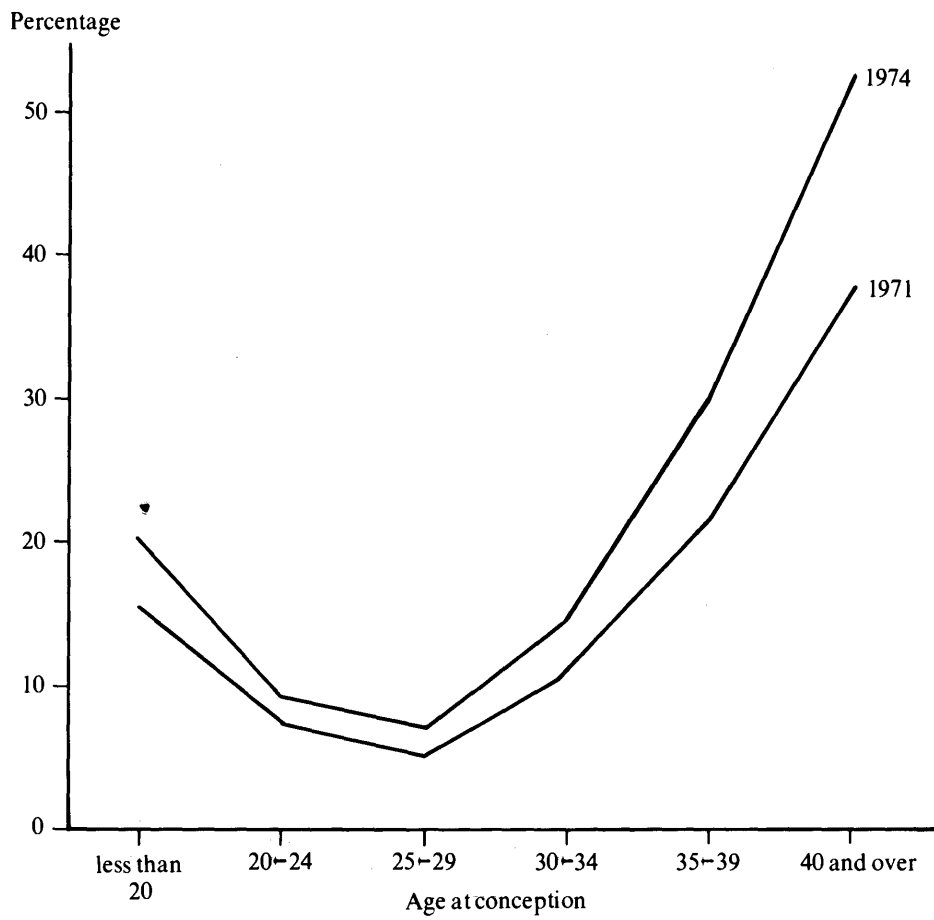
Table IV.O.8 Statistics of induced abortions in the Northern Territory, 1974 and 1975

| | 1974 | 1975 |
|--|-------|----------------------|
| Total number of abortions | 183 | 177 |
| out of them to Aboriginal women | 3 | 7 |
| Total number of live births in hospitals | 2 260 | 1 825 ^(a) |
| out of them to Aboriginal women | | 500 ^(a) |
| Total number of live births registered in the Northern Territory | 2 808 | 2 118 |
| Women concurrently sterilised | 24 | 29 |
| Age of women at the time of abortion: | | |
| less than 15 | 3 | 3 |
| 15-19 | 29 | 36 |
| 20-29 | 105 | 80 |
| 30-39 | 38 | 53 |
| 40 + | 8 | 5 |
| Parity: | | |
| 0 | 92 | 74 |
| 1 + | 89 | 103 |
| unknown | 2 | .. |
| Marital status: | | |
| married | 71 | 88 |
| non-married (incl. separated) | 112 | 89 |
| Women who had previous abortion | 30 | 21 |

(a) Includes stillbirths.

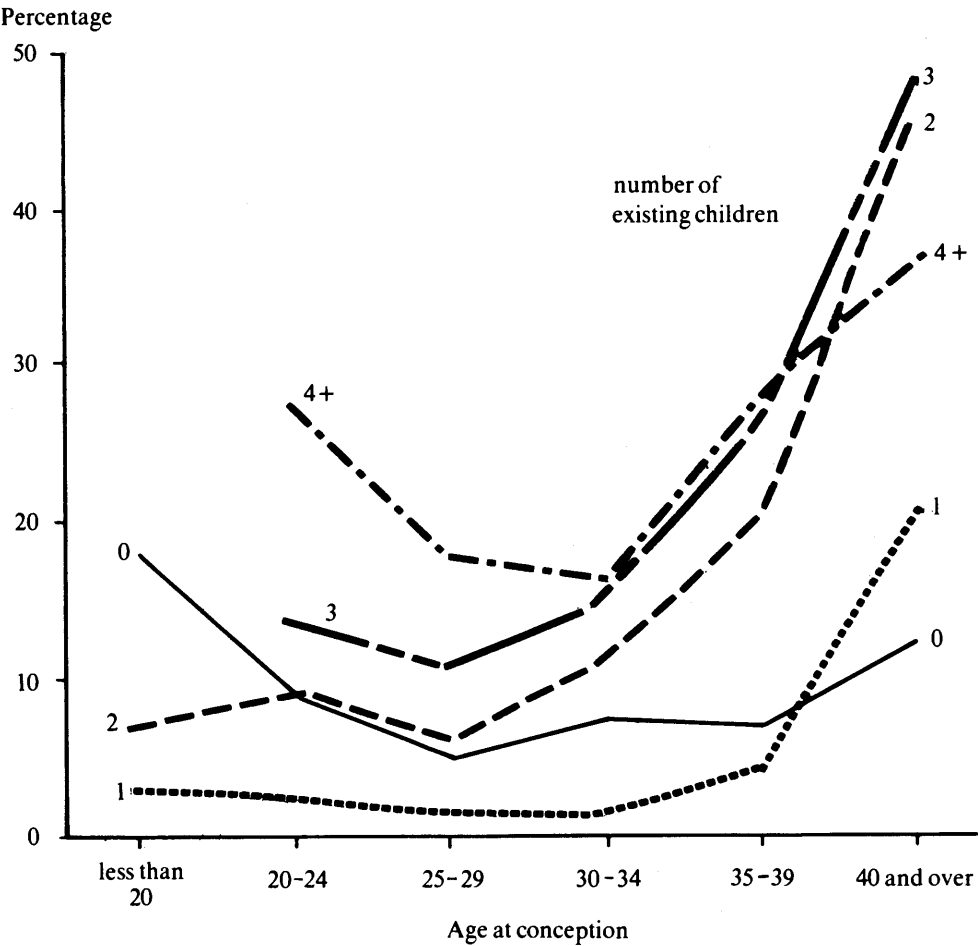
Source: Northern Territory Medical Service Bulletin, issues 3 to 10 (Australian Department of Health).

Figure IV.O.1 Proportion of all recorded pregnancies terminated by induced abortion, South Australia, 1971 and 1974



Recorded pregnancies = confinements (nuptial and ex-nuptial) resulting in live birth + induced abortions.

Figure IV.O.2 Proportion of pregnancies terminated by induced abortion, by woman's age and the number of existing children, South Australia, 1971



Annexe IV.P

The consequences (sequelae) of abortion

Report prepared for the Royal Commission on Human Relationships

Steering Committee:

Professor L. Cox

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Dr L. T. Ruzicka

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Introduction

1. This paper is written in accordance with the Commission's terms of reference:
... to include in [its] inquiry ... the social, psychological and medical results of termination of, or and failure to terminate unplanned or unwanted pregnancies.
2. The Commission received submissions from numerous groups and individuals on the subject of abortion. As much of this material is contradictory, the Commission found it necessary to have prepared for its use an overall review of published evidence and to conduct its own research. This research report contains the results of this review. A survey of complication rates of abortion in a sample of Australian hospitals is set out at Annexe IV.Q.

Sequelae of abortion defined

3. Sequelae of abortion are the effects of an induced abortion, either in association with the operation or following on from it. They can be physical, pathological or psychological in nature. Many authorities on the subject would also include social and demographic factors in relation to abortion sequelae.
4. Sequelae are classified as early or late. Early complications occur at the time of the procedure, or may follow in a few hours, or a few days. Late sequelae are long-term or latent effects, both physiological and psychological, or, in the wider sense, social and demographic.

Mortality of abortion

Supporting data

5. World figures on mortality are far more reliable than morbidity data, for reasons which will be outlined in the section covering morbidity. But this reliability pertains to legal abortion, not necessarily to illegal or criminal abortion.

Mortality of illegally induced abortion

6. For obvious reasons, statistics on illegal abortion are of dubious validity. Deaths due to illegal abortion may be ascribed to other causes, either deliberately or unintentionally. Hence deaths from illegal abortions may be significantly under-recorded.

There is probably no condition (with the possible exception of venereal disease) more likely to be affected by deliberate misreporting than abortion.¹

7. In the USA:

... not all abortion-related deaths are correctly identified on the death certificate. Although the extent of such misreporting is not known, there is reason to believe that the quality of registration of deaths by cause has improved since the early 1960s and that this improvement has extended to the correct reporting of abortion-related deaths, owing to the intense public controversy about abortion.²

8. However, despite the difficulties with data, medical researchers can make generalisations about mortality in relation to illegal abortion.

1. Emily Campbell Moore-Cavar, *International inventory of information on induced abortion* (Columbia University NY, 1974) p. 443.

2. *Reports on population-family planning*, no. 14 (2nd edn), 1975; p. 63.

United States

9. Tietze estimates that the minimum case fertility rate ratio associated with illegal abortion in the USA and other developed countries is 40 per 100 000 procedures. He compares this with the current risks associated with childbirth in the USA (14 per 100 000) and that of legal abortion (5 per 100 000).³

10. When it comes to reported deaths only in actual numbers, the Committee of the Institute of Medicine, working under the auspices of the National Academy of Sciences on the Joint Program for the Study of Abortion,⁴ states:

The replacement of legal for illegal abortion . . . is reflected in the substantial decline in the number of reported complications and deaths due to other-than-legal abortions since non-restrictive practices began to be implemented in the United States. The number of all known abortion-related deaths declined from 128 in 1970 to 47 in 1973; those deaths specifically attributed to other-than-legal abortion dropped from 111 to 24 during the same period, with much of that decline attributed to a reduced incidence of illegal abortions.⁵

11. Another way of looking at these deaths is in relation to the fertile female population: see table IV.P.1.

Table IV.P.1 Illegal abortion mortality rates, USA, 1968-73

| Deaths per 100 000 women | |
|--------------------------|-----------|
| | Age 15-44 |
| 1968 | 0.30 |
| 1969 | 0.31 |
| 1970 | 0.28 |
| 1971 | 0.18 |
| 1972 | 0.14 |
| 1973 | 0.06 |

Source: US Department of Health, Education and Welfare, Centre for Health Statistics, *Vital statistics of the US*.

12. The overall conclusion of the JPSA is that:

. . . the number of reported deaths from other-than-legal abortions declined steadily as less restrictive abortion legislation was passed and implemented throughout the country.⁶

13. Figure IV. P.1 illustrates this decline.

14. Another way of assessing numbers of illegal abortions and associated mortality and morbidity is to examine the figures on hospital admissions for incomplete or septic abortions. In the City of New York, during the period 1969 to 1973, these admissions were approximately halved.

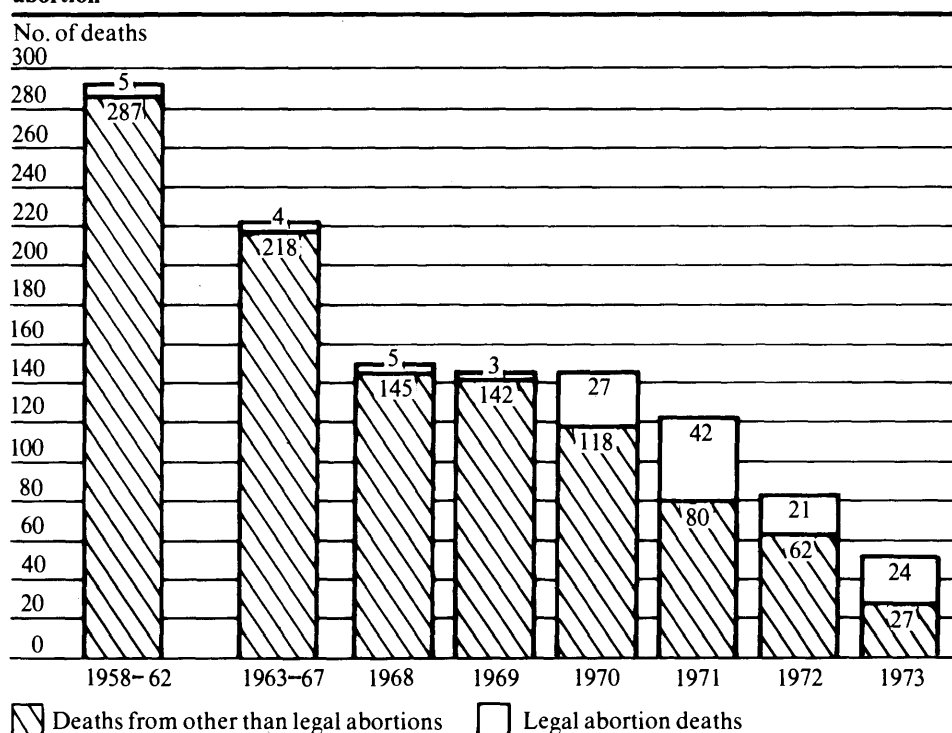
3. Christopher Tietze, 'The effect of legalisation of abortion on population growth and public health', *Family Planning Perspectives* 7, 3 (1975), p. 124.

4. The Joint Program for the Study of Abortion analysed nearly 73 000 cases in 66 different US facilities. The major findings have been published in *Legalised abortion and the public health* (National Academy of Sciences, 1975), to be referred to hereafter as the JPSA.

5. JPSA, p. 10; the US Department of Health, Education and Welfare, Public Health Service, Centre for Disease Control's Report (issued April 1976) *Abortion surveillance 1974*, gives figures which differ slightly but which present the same picture—64 deaths in 1972, 30 deaths in 1973 and 24 deaths in 1974 (this is combining the numbers from both illegally induced and spontaneous abortions), p. 48.

6. JPSA, p. 85.

Figure IV. P.1 Reported deaths associated with abortion, USA, 1958-73, by legal status of abortion



Source: C. Tietze, 'The effect of legalisation of abortion on population growth and public health', *Family Planning Perspectives* 7, 3 (1975), p. 126.

15. Table IV. P.2 illustrates hospital admissions for incomplete abortions.

Table IV. P.2 Admissions to municipal hospitals in New York City for incomplete abortions, 1969-73

| Years | Number of admissions | Number of births | Incomplete abortion admissions per 1000 births |
|-------|----------------------|------------------|--|
| 1969 | 6 524 | 27 842 | 234 |
| 1970 | 5 293 | 31 308 | 169 |
| 1971 | 3 643 | 27 998 | 130 |
| 1972 | 3 538 | 24 989 | 142 |
| 1973 | 3 253 | 24 502 | 133 |

Source: *International inventory of information on induced abortion*, New York (International institute for study of human reproduction, Columbia University, 1974), p. 642; see also *Lancet*, 28 June 1975, p. 1418.

('Incomplete' is a term used to cover both induced and spontaneous abortions as it is difficult to differentiate between the two; patients' accounts may not be reliable in circumstances where abortion is illegal.)

16. A similar picture emerges in the data from Brooklyn, Atlanta, Los Angeles and San Francisco.⁷

7. JPSA, p. 65.

17. The numbers of deaths from abortions classified as 'spontaneous' had by 1971 fallen to 20 per cent of the 1967 figures.⁸ This was considered by the JPSA to be due to a decline in illegal abortions formerly classified as spontaneous, some elective abortion of pregnancies which might have ended spontaneously, and an overall decline in the number of pregnancies due to increased use of contraceptive methods. The CDC (Centre for Disease Control) figures for spontaneous abortion deaths in the USA are twenty-three in 1972, nine in 1973, and eighteen in 1974; a percentage of these deaths were from septic spontaneous abortions caused by IUDs.⁹

18. Further evidence for this conclusion emerges from the experience of Harlem Hospital:

There was a dramatic decrease in the number of mid-trimester 'spontaneous' abortions of live-born non-surviving fetuses weighing 500 to 750 g. The incidence fell from 22 to 8/1000 births after liberalisation of abortion. A similar phenomenon was observed at Kings County Hospital in Brooklyn, another municipal hospital, and it is now realised that over half of such spontaneous abortions were, in reality, illegally induced abortions.¹⁰

United Kingdom

19. A similar picture emerges in the UK where induced abortion was legalised in 1967. G. E. Godber, chief medical officer of the Department of Health and Social Security, reports that recorded deaths due to illegal abortion fell from approximately thirty per year in the early 1960s to fifteen in 1969, eleven in 1970 and six in 1971.¹¹

20. Others believe that the actual number of deaths before the Act of 1967 was higher. Anthony Hordern estimates that fifty women per annum died from haemorrhage and sepsis in the UK.¹² Hospital admissions due to septic and incomplete abortions have declined significantly (see table IV. P.3).

21. As in the USA, there has been a decline in the number of abortion deaths classified as 'spontaneous' (see table IV.P.4).

Countries with restrictive abortion legislation

22. Countries with restrictive abortion legislation have higher rates of abortion-related case fatalities than those with liberal abortion legislation. This is caused partly by the fact that abortions are performed more often on women with medical complications, and partly by the inexperience of doctors who perform very few abortions. But primarily the deaths are from illegal abortions.¹³

23. In countries lacking good and accessible hospital care Tietze and Murstein estimate that deaths 'may reach or exceed 1000 per 100 000 illegal abortions.'¹⁴ For example, in Chile the incidence cannot be known, but in actual numbers the hospital admissions for incomplete and septic abortion rose from 12 963 in 1937 to 57 368 in 1960 and accounted for 38.8 per cent of all maternal mortality in 1963 (312 abortion deaths). Illegally induced abortion is a major public health problem in Chile, but large-scale contraceptive education is helping to reduce it.¹⁵

8. *ibid.*, p. 65.

9. *Abortion surveillance 1974*, p. 8.

10. Alan Guttmacher, 'Medical aspects of the abortion experience' in Howard J. & Joy D. Osofsky (eds), *The abortion experience* (Harper & Row, Maryland, USA, 1973), p. 536.

11. G. E. Godber, *British Medical Journal*, 18 November 1972, p. 424.

12. A. Hordern, *Legal abortion: the English experience* (Permagon Press, London, 1971), p. 5.

13. Christopher Tietze in Sydney H. Newman, Mildred B. Beck, Sarah Lewit, *Abortion, obtained and denied* (The Population Council, NY, 1971), p. 10.

14. C. Tietze & M.C. Murstein, 'Induced abortion: 1975 factbook', *Reports on population-family planning*, no. 14 (2nd edn), 1975, p. 58.

15. Carl W. Tyler, John D. Asher, Malcolm G. Freeman, in Newman et al., p. 115.

Table IV.P.3 London emergency bed service admissions (Female)

| Year | Total female admissions | Female admissions in connection with abortion |
|------|-------------------------|---|
| 1965 | 31 081 | 5 731 |
| 1966 | 29 244 | 5 101 |
| 1967 | 27 879 | 4 364 |
| 1968 | 27 465 | 3 740 |
| 1969 | 28 462 | 3 327 |
| 1970 | 27 334 | 3 210 |
| 1971 | 25 137 | 2 872 |
| 1972 | 25 455 | 2 549 |
| 1973 | 23 466 | 2 398 |
| 1974 | 21 018 | 1 941 |

Comment: All emergency admissions have decreased but those involving abortion have decreased more than others.

In 1965 abortion admissions constituted about 19 per cent of the total: by 1971 these had dropped to 11 per cent and in 1974 accounted for 9 per cent.

Source: *Abortion today*, no. 1 (British Pregnancy Advisory Service, London, 1975).

Table IV. P. 4 UK abortion deaths—actual numbers

| Year | Total | Legal abortions | Spontaneous | Induced for other reasons | Others and not specified |
|------|-------|-----------------|-------------|---------------------------|--------------------------|
| 1969 | 35 | 10 | 8 | 15 | 2 |
| 1970 | 32 | 10 | 7 | 11 | 4 |
| 1971 | 27 | 12 | 4 | 6 | 5 |
| 1972 | 26 | 10 | 2 | 7 | 7 |
| 1973 | 12 | 4 | 2 | 4 | 2 |
| 1974 | 11 | 6 | . | 2 | 3 |

Source: Dr Owen, Secretary of State for Social Services, in *Hansard* 897, 179 (1975), ref: H911.

24. Countries with more sophisticated after-care do somewhat better. Before France liberalised abortion access recently, the deaths from illegal abortion had been estimated at 5000 per year, but could have been three times as high. The annual number of abortions was estimated to be between 800 000 and one million, which gives a minimum death rate of 625 per 100 000 abortions.¹⁶ This would have been a pressing reason behind liberalisation of the law.

25. In countries where abortion is illegal but is performed by doctors regardless, the death rate from illegal abortion is near to the death rate from legal abortion. For example, in Taiwan, where abortion is technically illegal, but is generally performed by doctors (hence quasi-legal), the death ratio from induced abortion is estimated to be between 7.6 and 10.2 per 100 000 procedures, compared with a death rate for term pregnancies of 40 per 100 000 births.¹⁷

16. *Contemporary Obstetrician and Gynaecologist*, October 1974, p. 87; Dr Peyret, Vice-President of the French Social Affairs Commission, stated, in April 1973, that there were 400 000 to one million illegal abortions performed in France annually (*MJA*, 1 June 1974, p. 28).

17. R. Freedman, L. C. Coombs, M. C. Chang, T. H. Sun, 'Trends in fertility, family size preferences, and practice of family planning: Taiwan 1965-73', *Studies in Family Planning* 5 (1974), p. 270.

Australia

26. In Australia, total abortion deaths between 1964 and 1972 are recorded in table IV. P. 5.

Table IV. P. 5

| | Abortion deaths | Other maternal deaths |
|-------------|--------------------------------------|-----------------------|
| 1964-66 . . | 45 (1 therapeutic) | 183 |
| 1967-69 . . | 25 (6 therapeutic, 1 spontaneous) | 141 |
| 1970-72 . . | 25 (4 legal) | |

Source: National Health and Medical Research Council reports.

27. The Australian Council of the Royal College of Obstetricians and Gynaecologists has recently reported on its inquiry into legal abortion in Australia for the 3-year period 1970 to 1973, and found 'No death has been reported due to abortion alone.'¹⁸ Any abortion deaths in this period must therefore be due to an illegal procedure or a pre-existing medical condition.

28. The figures in table IV.P.6 from NSW show more precisely the effects of liberalisation on abortion-related mortality.

Romania

29. There is one country with experience of a liberal abortion law which subsequently reverted to a restrictive law. In 1966 Romania, concerned about its falling birth rate, restricted abortions to very narrow grounds. By the following year the birth rate had almost doubled. But women soon found alternatives to unwanted pregnancies.

While the rate of maternal mortality fell between 1967 and 1970 (from 59 per 100 000 live births in 1967 to 43 in 1970), the rate of abortion-associated maternal deaths more than tripled.

30. Stillbirths and infant mortality also increased.¹⁹

Table IV.P.7 Deaths attributed to illegal abortion in Romania, 1965-72

| | |
|------|-----|
| 1965 | 64 |
| 1966 | 83 |
| 1967 | 170 |
| 1968 | 221 |
| 1969 | 258 |
| 1970 | 314 |
| 1971 | 364 |
| 1972 | 370 |

Source: WHO Statistics Annual.

Romania now has the highest maternal mortality rates in Europe.

31. A diagrammatic analysis of the statistics appears in figure IV.P.2.

18. Submission 1246, RCOG, Australian Council.

19. *International Family Planning Digest* 1, 2 (1975), p. 12.

Table IV.P.6 Deaths from complications of pregnancy, childbirth and the puerperium—NSW, 1964–74

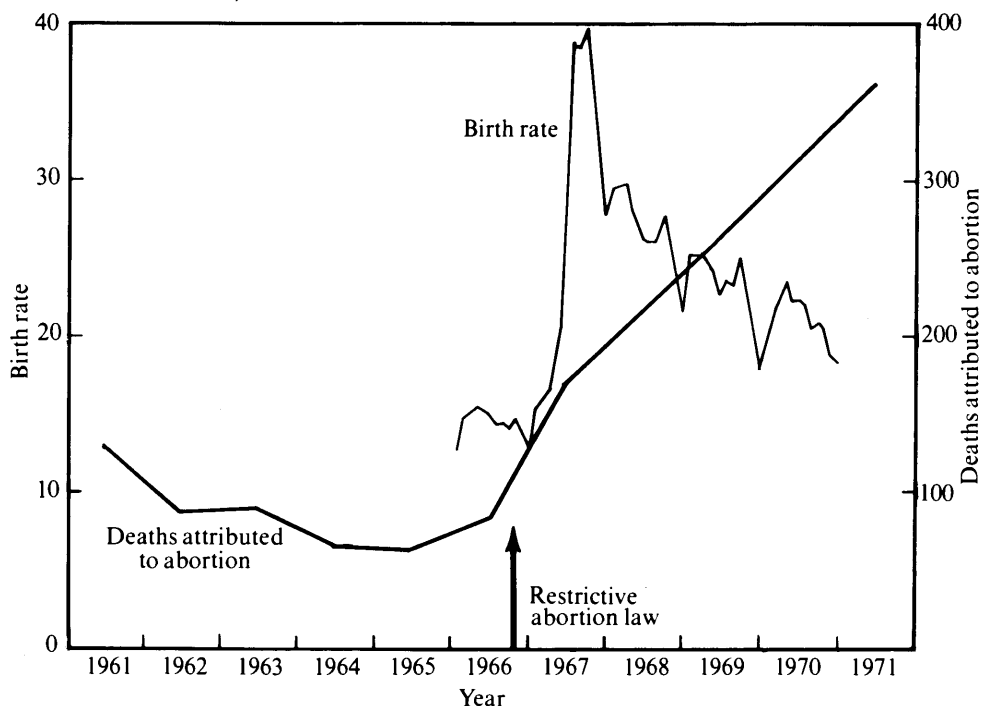
| Cause of death | ICD codes (8th revision) | Number of deaths | | | | | | | | | | |
|--|--------------------------|------------------|------|------|------|------|------|------|------|------|------|------|
| | | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 |
| Abortion: | | | | | | | | | | | | |
| Induced for medical or other legal indications | 640, 641 | (a) | (a) | (a) | (a) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Induced for other reasons (including criminal) | 642 | (a) | (a) | (a) | (a) | 3 | 0 | 2 | 3 | 0 | 0 | 0 |
| Other (including spontaneous) | 643, 645 | (a) | (a) | (a) | (a) | 3 | 0 | 2 | 3 | 0 | 0 | 0 |
| Total abortion | | 7 | 7 | 1 | 1 | 6 | 0 | 4 | 6 | 0 | 0 | 0 |
| Total maternal causes (including abortion) | | 28 | 25 | 22 | 19 | 28 | 15 | 22 | 15 | 10 | 7 | 12 |

(a) Not available as the 7th revision of the ICD did not classify abortions in this way.

Note: The Levine ruling which liberalised abortion in NSW took place in 1971. There have been no abortion deaths in NSW since liberalisation of the laws relating to abortion.

Source: NSW Health Commission, 1976.

Figure IV.P.2 Monthly birth rates per 1000 population, 1966–70, and number of deaths attributed to abortion, 1961–71: Romania



Note: Monthly birth rates computed on annual basis.

Source: C. Tietze & M. C. Murstein, 'Induced abortion: 1975 factbook', *Reports on Population-Family Planning*, no. 14 (2nd edn), 1975, p. 65.

Mortality of legal abortion

32. Deaths associated with legal abortion are required to be reported in all countries where it is legal, hence these figures may generally be considered fairly reliable. Moreover, data on mortality are also a fair index to the extent of morbidity. When mortality is high, so will morbidity be high and vice versa.

Mortality in the USA

33. In the United States there was an enormous increase in the number of legal abortions performed between the years 1963 to 1974 as women switched from illegal to legal abortion. But during this period the case fatality rate was reduced from 72.2 per 100 000 legal procedures to 3.1 per 100 000.²⁰

34. It should be kept in mind that legal abortions cited in the early periods would have been performed in many cases for medical indications. But the primary reason for the drop in fatalities would probably be the increase in skill of the operators.

20. Sources: 1963–68 C. Tietze, 'United States: therapeutic abortions, 1963–68', *Studies in Family Planning* 1, 59 (1970), pp. 5–7.
 1970–71 JPSA; four of these deaths could be attributed to the procedure; pre-existing conditions contributed to three deaths.
 1972 US Department of Health, Education & Welfare, Centre for Disease Control, *Abortion surveillance 1973* (published 1975).
 1973 E. Weinstock et al., 'Legal abortions in the United States since the 1973 Supreme Court decision', *Family Planning Perspectives* 7, 1 (1975), pp. 23–31.
 1974 *Abortion surveillance 1974*.

Table IV.P.8 USA mortality in association with legal abortion

| Years | Legal abortions | Number of deaths | Rate of deaths per 100 000 legal abortions |
|---------|----------------------|------------------|--|
| 1963-68 | 9 700 ^(a) | 7 | 72.2 |
| 1970-71 | 73 000 | 7 | 9.6 |
| 1972 | 586 800 | 21 | 3.6 |
| 1973 | 745 400 | 24 | 3.2 |
| 1974 | 763 476 | 24 | 3.1 |

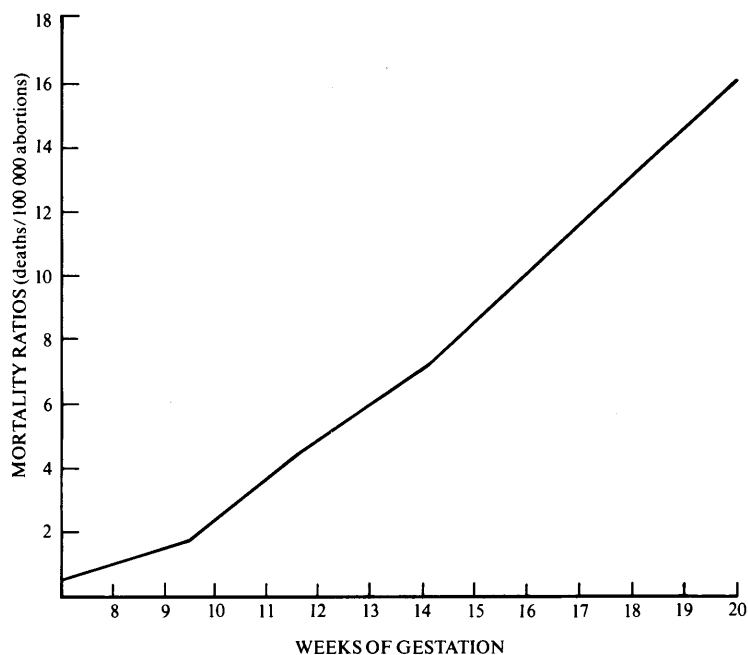
(a) Hospitals participating in PAS (Professional Activity Survey).

Source: JPSA, p. 78.

35. Similar results have occurred in other countries where abortion has been legalised; for example, Denmark's abortion mortality rate fell from 90.5 per 100 000 to 5.8 per 100 000 during 13 years of legalisation; Sweden's reduced from 96.4 to 8.0 per 100 000; Czechoslovakia 5.8 to 2.3; and Hungary 5.5 to 1.0.²¹

36. Of significant importance is the relationship between risk of death and gestation period. In the US during the period 1972 to 1973 the death ratio was 1.7 per 100 000 cases in the first trimester, and 12.2 in the second. For every week abortion is delayed the risk of death is increased.²²

37. Figure IV.P.3 illustrates this rate of increase.

Figure IV.P.3 Abortion mortality ratios by weeks of gestation, USA, combined 1972-73 data

Source: Joint Program for the Study of Abortion, *Legalised abortion and the public health* (National Academy of Sciences, 1975).

21. JPSA, p. 78.

22. JPSA, p. 73.

38. Table IV. P. 9 gives figures which show how death to case rates climb from 0.3 per 100 000 for less than 8 weeks gestation to 31.5 per 100 000 for more than 21 weeks.

Table IV. P. 9 Death to case rates for legal abortions by weeks of gestation, USA, 1972-74

| Weeks of gestation (weeks from LMP) | 1974 | | | 1972-74 | | |
|--|--------|----------------------|---------------------|---------|----------------------|---------------------|
| | Deaths | Cases ^(a) | Rate ^(b) | Deaths | Cases ^(c) | Rate ^(b) |
| < 8 | 1 | 325 379 | 0.3 | 3 | 747 550 | 0.4 |
| 9-10 | 5 | 219 133 | 2.3 | 13 | 581 002 | 2.2 |
| 11-12 | 3 | 117 388 | 2.6 | 12 | 330 537 | 3.6 |
| 13-15 | 5 | 42 242 | 11.8 | 12 | 129 536 | 9.3 |
| 16-20 | 7 | 49 820 | 14.1 | 28 | 147 160 | 19.0 |
| >21 | 3 | 9 514 | 31.5 | 6 | 30 282 | 19.8 |
| Total | 24 | 763 476 | 3.1 | 74 | 1 966 067 | 3.8 |

(a) Based on distribution of 555 085 abortions (72.7 per cent of total) in which weeks of gestation was known.

(b) Deaths per 100 000 abortions.

(c) Based on distribution of 1 459 495 abortions (74.2 per cent of total) in which weeks of gestation was known.

Source: US DHEW, Public Health Service, Centre for Disease Control, *Abortion surveillance, 1974* (1976), p. 34.

39. Another important factor in mortality rates is the method used. During the 1972-73 period in the US, it was found that vacuum aspiration and dilatation and curettage methods carried a mortality risk of 1.6 per 100 000 legal abortions, saline induction 15.4, hysterotomy and hysterectomy 61.3. The significant rise in mortality with the latter methods is due to the fact that they are generally performed later in the pregnancy on high risk women, with contributing factors such as greater age and high parity. But figures indicate that where abdominal methods are used in early pregnancies with low risk women, there is still a higher risk involved than for vaginal methods.²³

40. The figures from the Centre for Disease Control (1976) in table IV. P. 10 give a lower death to case rate for suction curettage than for D & C, as is consistent with other findings.

41. To put the above figures in perspective, the death to case rate from complications of pregnancy and childbirth (excluding abortion) was 14.1 deaths per 100 000 in the USA in 1973. That is, it was more than seven times the rate for the first trimester legal abortion, and a little higher than second trimester legal abortions.

23. Lane report, vol I, table E.2, p. 43.

Table IV. P. 10 Death to case rate for legal abortions by type of procedure, USA, 1972-74

| Procedure | Deaths | Cases ^(a) | Rate ^(b) |
|----------------------------|--------|----------------------|---------------------|
| Curettage | 35 | 1 748 558 | 2.0 |
| Suction | 26 | 1 436 120 | 1.8 |
| Sharp | 9 | 312 438 | 2.9 |
| Intra-uterine instillation | 33 | 183 906 | 17.9 |
| Hysterotomy/Hysterectomy | 5 | 13 126 | 38.1 |
| Other | 1 | 20 477 | 4.9 |
| Total | 74 | 1 966 067 | 3.8 |

(a) Based on distribution of 1 531 984 abortions (77.9 per cent of total) in which the type of procedure was known.

(b) Deaths per 100 000 abortions.

Source: *Abortion surveillance, 1974*, p. 34.

United Kingdom

42. The English experience reveals a similar increase in abortions performed and a similar reduction in deaths as legalisation continues. Case fatality rates for England and Wales:

| | |
|------|----------------------------------|
| 1968 | 18.0 per 100 000 legal abortions |
| 1969 | 37.0 |
| 1970 | 17.9 |
| 1971 | 12.6 |
| 1972 | 9.6 ²⁴ |
| 1973 | 4.0 ²⁵ |

43. In relation to the length of pregnancy UK figures show the same increase with gestation as do American figures, but overall they are higher. In 1969 the fatality rate for legal abortion was 6.62 per 100 000 in the first trimester; 1970-5.53; 1971-4.47. In the second trimester the figures were 17.02, 9.9, and 7.34 respectively.²⁶

44. The probable reasons for the higher death rates in first trimester abortions in the UK would include the higher percentage performed using abdominal methods and the greater numbers of concurrent sterilisations performed; sterilisation in the UK increases the likelihood of fatality ten times.²⁷

45. In the UK overall legal abortion deaths, currently averaging 4.0 fatalities per 100 000 cases, should be viewed in perspective with a case fatality rate of 18.0 per 100 000 pregnancies (excluding abortion deaths).²⁸

Eastern Europe and Japan

46. Countries with long experience in abortion have lower death rates than other parts of the world. They tend to receive most of their patients in the first trimester, and to avoid concurrent sterilisation.

24. *ibid*; p. 41.

25. *Abortion today*, no. 1 (1975), p. 5.

26. Lane report, p. 43.

27. *ibid.*, p. 45.

28. *ibid.*, p. 45.

47. In Hungary the number of legal abortions rose from 16 300 in 1954 to 170 000 in 1962, while the death rate declined from 5.6 to 1.2 per 100 000.²⁹ By 1970, Hungary was reporting 1 death per 100 000 legal abortions.³⁰ The mortality rate for live births in Hungary was at that time 41 per 100 000 births.³¹

48. In Czechoslovakia there were 3.1 deaths per 100 000 legal abortions in the period 1958–62; 2.5 during 1963–67³² and 2.3 in the period 1962–70.³³

49. For the years 1963–67 Yugoslavia has similar low rates with 0.4 deaths per 100 000 legal abortions (two deaths in 534 268 cases); 44.4 per 100 000 full-term deliveries (143 deaths in 322 382 cases); and 118.2 per 100 000 illegal abortions (227 deaths in 192 017 cases).³⁴

50. Japan records a death rate of 4.1 per 100 000 legal abortions during the period 1959–65, but this may be lower as many believe total numbers of abortions are significantly under-reported in Japan, for tax reasons.³⁵

51. To put these abortion deaths in perspective, we need to look at the non-abortion-related mortality, as shown in table IV. P. 11.

Table IV.P.11 Non-abortion maternal mortality: deaths from pregnancy, childbirth and the puerperium—excluding abortion—per 100 000 live births, 1969

| Country | Mortality ratio |
|-------------------------|------------------|
| Australia | 20 ³⁶ |
| England and Wales | 15 |
| United States | 19 |
| France | 20 |
| Czechoslovakia | 19 |
| Bulgaria | 26 |
| Poland | 30 |
| Hungary | 41 |
| German Federal Republic | 47 |
| Romania | 49 |
| Yugoslavia | 50 |
| Italy | 56 |
| Japan | 56 |
| Chile | 133 |
| Mexico | 146 |

Source: C. Tietze & D. Dawson, 'Induced abortion, a factbook', *Reports on population and family planning*, no. 14 (Population Council, 1973).

29. Hordern, p. 221.

30. JPSA, pp. 77–9.

31. Moore-Cavar, p. 442.

32. Hordern, p. 221.

33. JPSA, p. 7.

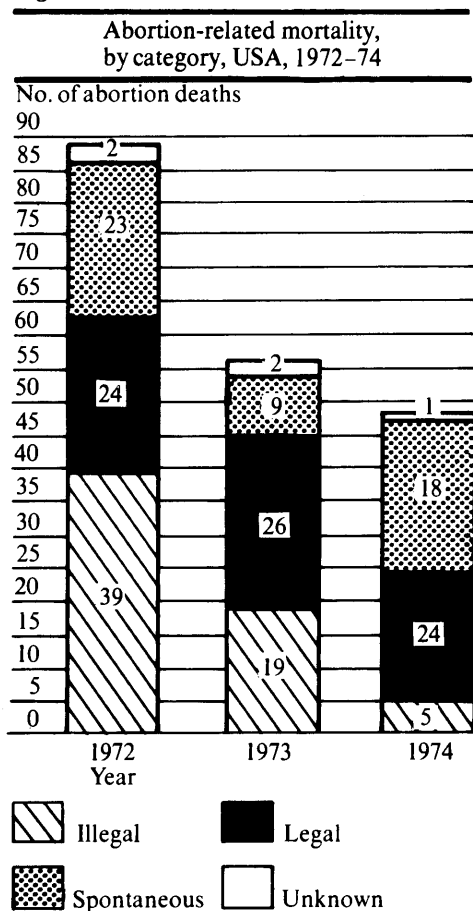
34. Berislav Beric et al., 'Accidents and sequelae of medical abortions', *Am JO&G* 116, 6 (1975), p. 814.

35. Tietze in Newman et al., p. 9; R. Abdel in I. R. Nazar (ed.), *Induced abortion: a hazard to one's health?* (IPPF, Beirut, 1972), p. 28.

36. Figure approximated from *National Health and Medical Research Council Report* on 1967–69. (Aboriginal women are generally over-represented in maternal deaths, approximately ten times their distribution in the overall female population.)

52. Legalisation of abortion in the United States has been accompanied by a sharp decline in abortion deaths—almost entirely due to the drop in illegal abortion deaths, from thirty-nine in 1972 to just three in 1975. It is estimated that the annual number of illegal abortions has declined from about 130 000 to 17 000 over the same period.

Figure IV. P. 4



Source: *Family Planning Perspectives* 8, 2 (1976), p. 87

Morbidity of induced abortion

Physical and pathological complications

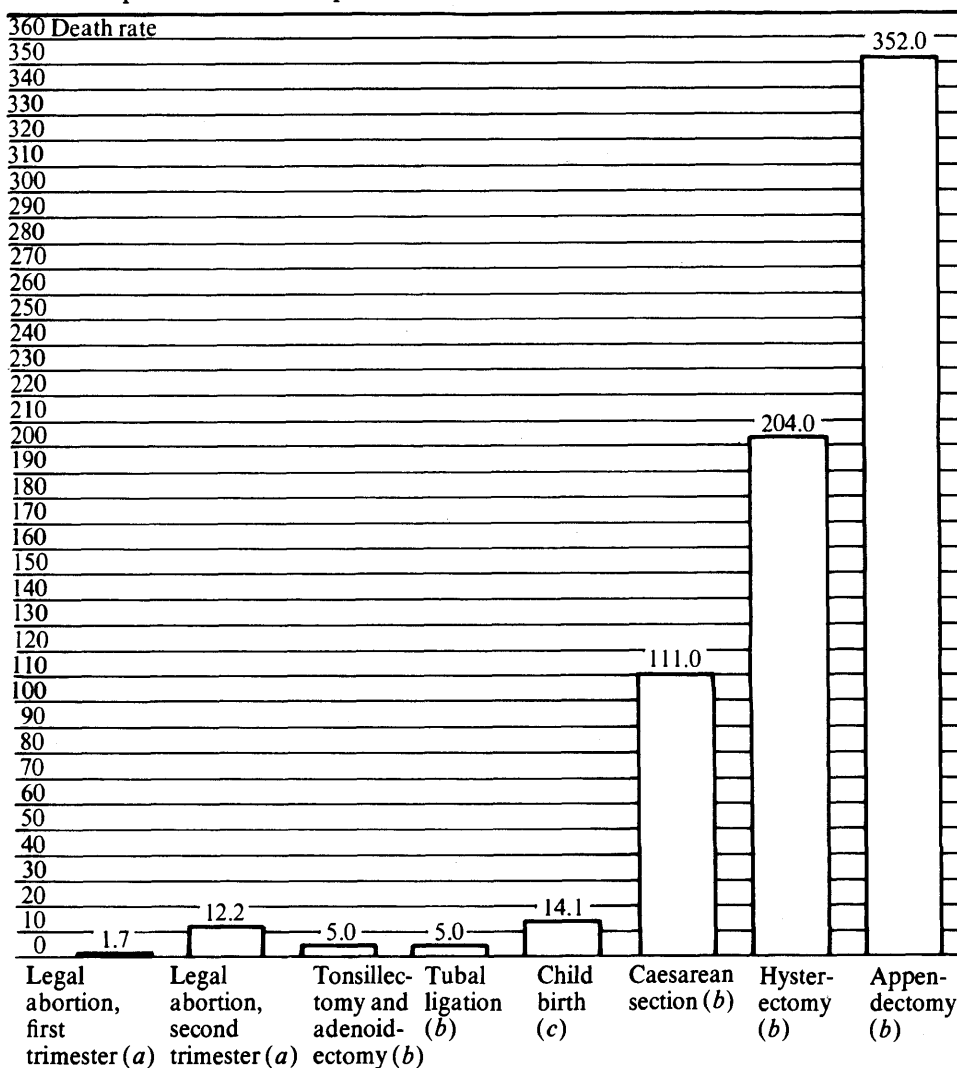
54. The following kinds of complications or morbidity may be associated with induced abortion procedures.

Vaginal methods (D & C, vacuum aspiration etc.)

- (a) Reactions to anaesthesia, both local and general.
- (b) Immediate—haemorrhage; laceration or stretching of the cervix; perforation of the uterus.
- (c) Post-abortion infections in the pelvic area; retained products which cause bleeding and infection.

Figure IV. P. 5

Death rate per 100 000 selected procedures, USA



(a) Based on 1972-73 data from the Centre for Disease Control.

(b) 1969 data from C. G. Child III, 'Surgical intervention', in *Life and death and medicine* (W. H. Freeman, San Francisco, 1973), p. 65. This book originally appeared as the Sept. 1973 edition of *Scientific American*.

(c) National Centre for Health Statistics, DHEW, 'Summary report: Final mortality statistics, 1973', *Monthly vital statistics report*, vol. 23, no. 11, Supplement (2), 1975.

Source: *International Family Planning Digest* 1, 3 (1975), p. 10.

Intra-uterine methods (saline induction, prostaglandin induction)

(a) Reactions to anaesthesia.

(b) Saline induction may cause damage to the central nervous system if the saline solution enters the bloodstream; it may also cause disturbances of the clotting mechanism; possible cervical damage; infection.

- (c) Prostaglandin induction sometimes has side effects of muscular spasm, vomiting and diarrhoea; cervical damage is a possibility; haemorrhage; infection.

Abdominal methods (hysterotomy, hysterectomy)

- (a) Reactions to anaesthesia.
- (b) Endometriosis of the wound; peritonitis; infection or rupture of the wound; thrombosis; pulmonary embolism; phlebitis; pelvic infection.

55. It should be noted that many of the above will also occur in a percentage of cases in association with childbirth. The Lane report states:

Haemorrhage can occur prior to or following delivery, not infrequently requiring blood transfusion. Caesarian section is performed in about 5 per cent of patients, with all the attendant risks of an abdominal procedure and a permanent scar on the uterus. The uterus can rupture spontaneously or be perforated if removal of retained products is necessary. Pelvic infection can occur. Thus, all the major hazards associated with termination of pregnancy can also occur before or after childbirth at term.³⁷

Difficulties of assessment

56. The criteria for definition of complications differ among reporting physicians. Examples are:

- (a) A certain amount of blood loss accompanies both induced abortion and full-term birth (or any surgical procedure). To some physicians, 200 ml may constitute an excess of bleeding; to others it may be 500 or 750 ml. The JPSA decided on 1000 for a major complication, lesser amounts were included in total complications. Whether or not the blood loss occurs at the time of the operation or some days later may also be a significant factor in whether or not it is reported.
- (b) If the cervix is stretched or damaged in the course of dilatation, the practice of suturing and of reporting may vary with different practitioners.
- (c) Similarly, some may report only serious uterine perforation; others will report even suspected perforations.
- (d) A slight temperature rise for a few hours may be considered a complication by some; others may register only more serious and prolonged fevers. Similarly with vomiting and diarrhoea.

In many studies the researcher cannot know which criteria have been used.

57. Another related difficulty in reporting which significantly affects complication rates lies in the fact that one patient may be reported as having two or more complications when in fact they may be factors of the same condition. For example, a patient with retained products may be reported as experiencing fever and haemorrhage; they may also be accounted for under a general heading 'retained products'. Hence one problem has caused three notations.

58. The method by which the abortion is induced can affect the risks involved, for example:

In early pregnancy dilatation and curettage carries slightly more risk than vacuum aspiration.

Saline induction will be accompanied by more complications than will prostaglandin induction.

Hysterotomy or hysterectomy carry more risks than any other methods.

37. Lane report, vol I, p. 49.

Also methods which may be suitable at one stage in pregnancy may carry more risks if used at a later stage in pregnancy.

If the more risky method has been chosen, morbidity rates will obviously be affected.

59. A crucial factor in complication rates is the length of pregnancy when the operation occurs. After the twelfth week complications may be three or four times higher than for the first trimester. If studies do not indicate gestation periods in assessing their figures, we cannot know the relative rates for each stage of pregnancy.

60. The age of the patient, particularly if she is very young, or over 35, may also influence the outcome, as will her previous obstetric history—whether or not she has had children, how many, and how closely they were spaced. Few studies allow for these variables.

61. Induced abortion performed by qualified practitioners is still a fairly new procedure. Most figures show a decline in complication rates with experience, and with the acquisition of knowledge as to which method is safest for each stage and each patient.

62. Varying motivations of the operator on a subconscious level may be a factor in abortion morbidity not present in other surgical procedures. This factor is difficult to assess objectively.

63. Whether or not the patient undergoing an abortion is healthy or has already existing physical or pathological conditions will affect complication rates. The JPSA report found that pre-existing conditions more than doubled the likelihood of complications in association with abortion. Few studies indicate when this factor is present.

64. Increased likelihood of complications also occurs if sterilisation or other procedures accompany the operation. The JPSA found it increased complication rates by at least four times.

65. Under-reporting may be more likely with abortion than with other procedures. At present a patient may live some distance from the place where she obtained the operation. She may give a false name or address. On the other hand, it is also true that patients who *do* experience problems after release are more likely to report back and are more easily traced than those who experience no problems. Some health regulations require that abortions be reported within a specified time limit. If that time is less than one week, there may also be some slight under-reportage on this account. But most early complications of abortion occur either at the time of the procedure, or 3 or 4 days later; very few after a week.

66. There is considerable difficulty in comparing world data, as different countries report on different time periods, have varying amounts of experience and use different criteria. The use of statistics differs also, and sometimes it is not possible to compare one system with another. For example, it is impossible to compare the English findings with the major USA JPSA study. The latter has recorded any complications at all, such as a single day of fever or vomiting, under 'total' complications; more serious events, such as the need for major surgery, blood transfusions, sustained fever, more prolonged illness, would be classified as 'major' complications. English studies have only one category, and this is likely to vary from middle range complications to serious, according to each reporter's personal inclinations. Abortion laws differ also by country, allowing different degrees of access to abortion, a factor which may affect mortality and morbidity rates.

67. Complications in association with abortion should also be compared with complications in association with childbirth. This needs a comparative methodology; but here again the variables are complex.

68. The complexities involved in reporting and assessing abortion complications may result in significantly different findings in morbidity studies. Table IV.P.12 summarises some of these differences and how they may affect morbidity rates.

69. Possible factors present in low and high morbidity rates:

Table IV.P.12 Morbidity of induced abortion

| Low morbidity rates | High morbidity rates |
|--|--|
| (a) Long experience of operators—almost all studies indicate a decline in complications with experience. | (a) Inexperience of operators—a specialist with little experience in an abortion procedure may have a higher complication rate than a general practitioner or trained paramedic with long experience. |
| (b) Operators who are highly motivated and who exercise great care. | (b) Operators who disapprove of the procedure, who feel resentful towards patients who seek abortion, are less motivated to exercise the care needed to keep complications down. This would probably be an unconscious motivation. |
| (c) Use of the safest methods available for each stage of pregnancy. | (c) Misuse of methods—studies with high complication rates can be shown to be using methods which involve dilatation of the cervix too late, and dangerous abdominal methods instead of available safer methods. |
| (d) Generally high medical standards. | (d) Medical standards vary by facilities, e.g. some will have higher post-operative infection rates than others. |
| (e) Some under-reporting through inability to follow up all patients. | (e) More complete reporting due to ability to record those complications which may occur some time after the procedure. |
| (f) Recording of only serious or significant complications. | (f) Recording of all possible complications, even minor ones which would be considered of little consequence in full-term birth or other surgical procedure. |
| (g) Separation of true morbidity of abortion from associated morbidity or concurrent sterilisation or pre-existing illness; and relatedly Reluctance to perform sterilisation with abortion. | (g) Failure to separate complications of abortion from those occasioned by concurrent procedures or pre-existing medical conditions. |

The American experience

70. The major US study, the Joint Program to Study Abortion, reported on almost 73 000 cases. Morbidity findings are summarised in table IV.P.13.

Table IV.P.13 Total and major post-abortion complications per 100 women obtaining abortions by gestation, procedure, pre-existing complications and concurrent sterilisation, total patients and local patients with follow-up (FU), JPSA, 1 July 1970-30 June 1971

| Type of abortion | Total complications | | Major complications | |
|---|---------------------|------------------------|---------------------|------------------------|
| | Total patients | Local patients with FU | Total patients | Local patients with FU |
| Complication rates per 100 women obtaining abortions | | | | |
| All patients | | | | |
| 12 weeks or less | 5.2 | 7.2 | 0.6 | 1.1 |
| 13 weeks or more | 22.2 | 26.1 | 2.2 | 3.0 |
| Patients <i>without</i> pre-existing complications, by procedure | | | | |
| Suction ^(a) | 4.2 | 6.1 | 0.4 | 0.6 |
| D & C ^(a) | 6.0 | 8.2 | 0.5 | 0.8 |
| Saline ^(a) | 23.4 | 27.2 | 1.7 | 2.4 |
| Hysterotomy ^(b) | 33.4 | 32.9 | 6.7 | 6.9 |
| Hysterectomy | 49.9 | 50.9 | 14.3 | 15.6 |
| Patients <i>without</i> complications or sterilisation | | | | |
| 12 weeks or less | 4.2 | 6.2 | 0.4 | 0.6 |
| 13 weeks or more | 20.6 | 26.0 | 1.6 | 2.1 |
| Patients <i>with</i> pre-existing complications, <i>without</i> sterilisation | | | | |
| 12 weeks or less | 12.7 | 17.1 | 1.4 | 2.0 |
| 13 weeks or more | 29.9 | 35.1 | 4.6 | 6.7 |
| Patients <i>without</i> pre-existing complications, <i>with</i> sterilisation | | | | |
| 12 weeks or less | 25.9 | 28.0 | 6.1 | 7.2 |
| 13 weeks or more | 35.8 | 35.4 | 8.2 | 8.0 |
| Patients <i>with</i> pre-existing complications and sterilisation | | | | |
| 12 weeks or less | 43.0 | 46.2 | 14.9 | 17.1 |
| 13 weeks or more | 56.5 | 60.4 | 13.8 | 17.4 |

(a) Without tubal sterilisation.

(b) With tubal sterilisation.

Source: Tietze & Dawson; JPSA, p. 50.

Summarised, the findings are as follows:

71. Major complications were lowest within the first 12 weeks of pregnancy—1.1 per 100 patients with local follow-up, and 3.0 for those 13 weeks and over. When the figures are adjusted to separate out patients with pre-existing medical complications and those undergoing concurrent sterilisation, the rates are lower—0.6 for the first trimester and 2.1 for the second. Approximately three out of four abortions were performed in the first trimester, and the proportion of late abortions decreased significantly during the year of the study.³⁸

72. Those women who had pre-existing medical conditions, and women who underwent sterilisation in association with abortion, had substantially higher complication

38. JPSA, p. 98.

rates than did women subject only to the risks of the abortion procedure itself. Pre-existing conditions increased the likelihood of total complications three times over that for healthy women³⁹; sterilisation could increase the risks up to ten times. If the patient had both pre-existing medical conditions and sterilisation, she was more than ten times as likely to develop complications as a woman without these associated events. In terms of major complications, the risk could be more than thirty-five times as high.

73. The JPSA also noted that free-standing clinics experienced a lower incidence of total complications than hospital outpatients or inpatients. Generally, this would be due in part to the fact that hospitals handle more patients with pre-existing medical complications, perform sterilisations in association with abortion, and receive more patients in advanced stages of pregnancy. Also, there is more likelihood of under-reportage of delayed complications with clinic patients. But a major difference to account for the better results in the clinics would lie in the greater experience of their physicians. Table IV.P.14 from the JPSA has separated out patients with pre-existing conditions and/or sterilisation and includes only those with completed follow-up. All were aborted by suction, hence should have been early abortions. It illustrates the complication rate differences by facility, by complication.

Table IV.P.14 Number and complication rates of local patients with follow-up who were aborted by suction, by type of facility

| Type of complication | Type of facility | | |
|-----------------------------------|---------------------|----------------------|-------------------------------|
| | Hospital inpatients | Hospital outpatients | Free-standing clinic patients |
| Number of patients ^(a) | 5 350 | 11 538 | 6 968 |
| | Rates per 100 women | | |
| Perforation of uterus | 0.6 | 0.3 | 0.2 |
| Other injury | 1.8 | 1.2 | 0.2 |
| Haemorrhage | 2.0 | 1.2 | 0.6 |
| Pelvic infection | 1.4 | 1.1 | 0.3 |
| Haemorrhage and infection | 0.4 | 0.3 | 0.1 |
| Fever only | 0.9 | 0.4 | 2.0 |
| All other | 0.7 | 1.0 | 0.4 |

(a) Excludes patients with pre-existing complications and/or sterilisation.
Source: C. Tietze & S. Lewis, 'JPSA: early medical complications of legal abortion', *Studies in Family Planning* 13 (1972), p. 116; JPSA, p. 52.

In all but one category clinics incurred consistently lower complication rates.

74. Since the JPSA study, other US studies have found similar complication rates. For example, the Preterm clinic in Washington, DC, reported major complications in 1.4 per 100 patients with completed follow-up.⁴⁰ This was using suction curettage in 20 248 first trimester abortions.

39. Pre-existing medical conditions include diseases of the circulatory system—heart disease, hypertension; diseases of the reproductive system—uterine fibroid tumours; asthma; diseases of the urinary tract; anaemia; diabetes; mental disorders or epilepsy. All these would also increase the likelihood of morbidity in association with childbirth.
40. Jane E. Hodgson, 'Major complications of 20 248 consecutive first trimester abortions: problems of fragmented care', *Advances in Planned Parenthood* IX, 3 and 4; *Excerpta Medica*, 1975.

75. Out of the 20 248 patients, 197 (or 0.98 per cent) had significant major complications. Ninety (0.44 per cent) experienced retained tissue, a problem which should decrease with the experience of operators; forty-five (0.22 per cent) developed pelvic infection; there were twenty-five uterine perforations and one cervical laceration (0.13 per cent).

76. The increasing benefit of accrued experience was shown by the fact that sixteen of the twenty-five perforations occurred among the first 10 000 patients; nine among the second. Three of the perforations were found to be serious; none of the others required more than conservative therapy.

77. Dr Hodgson believes that 'Complication rates can be further lowered by elimination of fragmented post-abortion care'.⁴¹ It is the practice of patients travelling some distances to obtain abortions, and the subsequent difficulty in receiving good follow-up care, that presently keeps complication rates higher than they need be.

78. The Preterm clinic also experimented with prophylactic administration of antibiotics and found this practice reduced the number of complications by two-thirds, and the number of hospital days required for treatment of complications by three-fourths. These findings came from a prospective study of 4000 patients, half of whom received antibiotics, half did not.⁴² There are, however, some who would argue that the complication rate for early abortions is low and that these complications are not serious enough to warrant such treatment, with the possible risk of building up resistance to these drugs in women who do not require them.

The English experience

79. Keeping in mind the manifold difficulties of assessing complication rates without knowing the criteria underlying them we find it extremely difficult to compare US and English data. As mortality of induced abortion is slightly higher in the UK, it is therefore likely that morbidity would also be slightly higher, but one cannot be dogmatic about this given the problems of assessment. Most UK complication rate figures are in themselves rather meaningless; but if several sets of figures are available, some useful generalisations can be made.

80. Table IV.P.15 taken from the Lane report gives us the rates of sepsis and haemorrhage by gestation period.

Table IV.P.15 Complications: Rate per 1000 notified abortions legally induced 1969, 1970 and 1971—all places

| Gestation period | Sepsis | | | Haemorrhage | | |
|------------------|--------|------|------|-------------|------|------|
| | 1969 | 1970 | 1971 | 1969 | 1970 | 1971 |
| 0-12 weeks | 6.7 | 4.8 | 3.0 | 6.6 | 4.8 | 3.0 |
| 13 or more weeks | 12.5 | 10.6 | 6.1 | 12.9 | 8.4 | 5.2 |

Source: Lane report, vol. I, p. 47.

81. These figures indicate that second trimester abortions have approximately twice the rates of sepsis and haemorrhage as first trimester abortions.

41. *ibid.*, p. 52.

42. Jane E. Hodgson, B. Major, K. Portmann, F. W. Quattlebaum, 'The prophylactic use of Tetracycline for patients undergoing first trimester abortions: a clinical model for the determination of the efficacy of prophylactic antibiotics', *Family Planning Perspectives* 1, 3 (1975).

82. There was a steady decline in all categories from 1969 to 1971, suggesting an improvement in technique with experience. All rates were halved or better over the 3-year period.

83. Table IV.P.16 examines these complications by method and gestation period.

Table IV.P.16 Complications recorded in notifications of abortions by length of gestation and method of termination: England and Wales 1971

| Complications | Method of termination | | | | | | |
|-----------------------------|-----------------------|-----------------------------|-------------------|------------------|------------|----------------|-------------------|
| | All methods | D & C only plus with others | Vacuum aspiration | Hysterotomy only | Utus paste | Intra-amniotic | Hysterectomy only |
| Gestation under 13 weeks | 95 513 | 48 588 | 40 949 | 4 284 | 555 | 115 | 394 |
| Sepsis no. | 282 | 76 | 141 | 32 | 13 | .. | 17 |
| Rate ^(a) | 3.0 | 1.6 | 3.4 | 7.5 | 23.4 | .. | 43.1 |
| Haemorrhage no. | 282 | 75 | 153 | 23 | 21 | 3 | 2 |
| Rate ^(a) | 3.0 | 1.5 | 3.9 | 5.4 | 37.8 | 26.1 | 5.1 |
| Gestation 13 weeks and over | 28 260 | 12 573 | 5 974 | 6 708 | 423 | 1 500 | 750 |
| Sepsis no. | 174 | 27 | 35 | 52 | 11 | 23 | 22 |
| Rate ^(a) | 6.1 | 2.1 | 5.9 | 7.8 | 26.0 | 15.3 | 29.3 |
| Haemorrhage no. | 146 | 36 | 58 | 27 | 2 | 15 | 7 |
| Rate ^(a) | 5.1 | 2.9 | 9.7 | 4.0 | 4.7 | 10.0 | 9.3 |

(a) Rate per 1000 notified abortions (specific to that type of termination and gestation period). Source: OPCS.

Source: Lane report, p. 48.

84. While methods used are closely related to the duration of pregnancy, some methods are safer than others given the same duration. In the first trimester, or the under 13 weeks category, D & C and VA had significantly lower rates of both sepsis and haemorrhage than other methods. In the more advanced pregnancies the picture is not as clear. Again the incidence was twice as high in most cases as for earlier pregnancies, while the methods which are suitable for the earlier pregnancies do not do as well with the later pregnancies.

85. Reported complications by groups and individuals revealed startling disparities—Stallworthy's 11 per cent need for re-evacuation for retained products compared with Bluett's 0.1 per cent in this category; Stallworthy gave 9.5 per cent of his patients a blood transfusion; none of Bluett's needed transfusions.⁴³ Only some of these differences can be accounted for by differences in methods and gestation periods.

86. The series reported on by Stallworthy et al.⁴⁴ has been referred to in many submissions to the Commission and should be looked at more closely. Their results are disquieting. In a group of 1182 patients, almost 17 per cent (200) lost more than 500 ml of blood, among them the 9.5 per cent (112) mentioned above who required transfusion; 4.2 per cent (50) experienced cervical laceration and 1.2 per cent perforation (14).

43. Lane report, p. 50.

44. J. A. Stallworthy, A. S. Moolgoaker, J. J. Walsh, 'Legal abortion: a critical assessment of its risks', *Lancet*, 4 December 1971, pp. 1245-9.

87. The study covered the period from 1968 to 1970, or soon after the passage of the Abortion Act. The experience of other, more recent, studies and results from those with longer experience can give us insights into why this study found such high morbidity.

88. Abdominal tubal ligation was performed on 100 (12.32 per cent) of the 812 patients who were aborted by vacuum aspiration and/or curettage. Of 70 patients undergoing hysterotomy (6 per cent of all patients), 44 were sterilised by tubal ligation; 106 patients, or 9 per cent, underwent hysterectomy, a high risk method. Totals for sterilisation were 144, or 17.73 per cent of all patients; totals for high risk methods were 176, or 14.89 per cent.

89. Fifty, or 4.2 per cent, of the patients were terminated because their lives were in danger; presumably they were very ill women. There is no indication as to how many others had medical conditions which may have influenced the outcome.

90. Of 812 patients whose pregnancies were terminated by vacuum aspiration and/or curettage, only 27 per cent or 219 of the patients were less than 10 weeks pregnant (gestation); other studies with far lower morbidity rates do not use the method past this time.

91. Three hundred and seventy patients, or 31.3 per cent in the series, were past the 14 weeks gestation period, and exposed to the greater risks of second trimester abortion.⁴⁵ Moreover, the second trimester methods used, with the exception of the prostaglandin induction method used for only 4.2 per cent, are now considered to be best avoided, except in cases where hysterectomy is medically indicated for reasons other than the abortion.

92. Post-abortion infection occurred in 27 per cent of the patients in this series. This is an unusually high infection rate and should cause concern with regard to the standards of surgical hygiene; it would probably not be tolerated with any other surgical procedure. A percentage of the infections followed sterilisation or hysterectomy, but many would have been due to retained products.

93. Eleven per cent (or 130) of the patients required re-evacuation of the uterus; 44 per cent of these were following mid-trimester abortion, an indication both of the difficulties of performing second trimester abortions with first trimester abortion methods and of the inexperience of the operators.

94. Thirty-nine, or 4.8 per cent, of the patients experienced demonstrable cervical laceration. Hegar dilators larger than Nos 12 and 14 were used in the majority of cases, and a fair number of cases respectively. Other practitioners have found a high rate of cervical damage when these dilators, rather than tapered dilators, are used. For that reason the Hegar dilators have now been discarded by most experienced practitioners. Soft cannulas have also brought significant improvements.

95. Two patients required abdominal hysterectomy because the uterus was ruptured during vacuum aspiration—an accident not found anywhere else in the medical literature.

45. A study by David T. Y. Lui, Terry Martin and Ian Hudson, 'Comparative morbidity after vaginal termination with regard to parity and gestational stage', *British Journal of Clinical Practice* 28, 5 (1974), pp. 170-1, indicates that: 'compared with first trimester abortions there was a statistically significant twofold increase in morbidity when vaginal termination of a mid-trimester pregnancy was attempted'.

96. As with the Ljubljana study and Miller's study, below, the senior operators incurred most of the more serious complications, which perhaps implies that experience in one surgical procedure does not necessarily give an advantage in another; low motivation or lack of flexibility in learning new methods may also be factors inhibiting some senior operators. Another possibility is that senior operators get more difficult cases, but the studies give no indication of this.

97. In comparing the morbidity of this study with that of others, we are in agreement with the authors when they declare: 'We are proud neither of the number of pregnancies which have been terminated, nor of the complications described.'⁴⁶ In any event, other studies have shown these high rates to be unnecessary.

98. The Stallworthy study is an unfortunate example of abortions performed in a period of inexperience of the problems involved. Correct use of methods and the use of tapered dilators rather than Hegars should have cut down these rates considerably. Moreover, we cannot know the true complication rates as several relevant associated factors have not been isolated.

99. According to the authors, the study has 'already helped to improve standards of safety for patients in Oxford'⁴⁷ hence the risks cited in this study need not be considered inevitable or unchanging.

100. In contrast with the Stallworthy et al. Oxford findings, we can compare a more recent English study which employed the suction technique, some using a soft flexible catheter. Dr Ian Hudson⁴⁸ reported on 18 193 terminations performed during the period 31 October 1971 to 31 July 1973 at the British Pregnancy Advisory Service Wiston's Nursing Home in Brighton. The soft catheter was introduced in July 1972, and 4685 of the terminations (25.75 per cent) were performed by this method. Great care was taken to follow up latent complications if the patient was to report back to another doctor or facility.

101. Of the series, there were sixteen cases of perforation or 0.13 per cent, in contrast to Stallworthy's 1.2 per cent. Half of the cases were treated conservatively, with no further complications arising. The other half were treated successfully via laparotomy.

102. There were eight cases of retained products, or 0.04 per cent, compared to Stallworthy's 11 per cent of cases experiencing this problem.⁴⁹

103. Twenty-five (0.14 per cent) of the patients received a blood transfusion, but sixteen were given *before* the operation because of diagnosed anaemia. We do not know how many of Stallworthy's subjects were anaemic prior to the operation, but in any event this is a significantly lower percentage than his 9.5 per cent requiring transfusion.

104. One hundred and fifty-three cases or 0.84 per cent of the patients experienced post-operative bleeding and were readmitted for treatment. Only eighteen, or 0.09

46. Stallworthy et al., p. 1245.

47. *ibid.*, p. 1249.

48. Hudson, 'Analysis of complications after vaginal termination', *British Journal of Clinical Practice* 28 (1974), p. 170.

49. A prospective study by M. Stone and M. G. Elder, 'Evaluation of sonar in the prediction of complications after vaginal termination of pregnancy', *American Journal of Obstetrics and Gynaecology* 120, 7 (1974), pp. 890-4, found that the use of ultrasonic scanning to determine whether retained products of conception are present after abortion is of significant value. The use of this device was found to predict 76 per cent of those patients likely to develop complications following vaginal termination of pregnancy.

per cent, of the patients incurred post-operative infection; this low figure (compared to Stallworthy's 27 per cent) was achieved in part by a 5-day course of prophylactic antibiotics routinely administered.

105. Dr Hudson notes a total of 210 complications in the series, or 1.15 per cent, of which thirty-seven or 0.79 per cent were incurred with the use of the Karman catheter. He therefore advocates the flexible soft catheter with vacuum aspiration as the safest method of terminating pregnancies.

106. Another UK study confirms the findings of Dr Hudson and the BPAS. Lewis et al.⁵⁰ found that vacuum aspiration with a flexible cannula permitted a short operative time, small blood loss and low incidence of complications. The incidence declined significantly as operators became more experienced.

107. Other recent studies show how low morbidity can be when experienced operators use knowledge and skills acquired as abortion experience increases. Hull et al.⁵¹ reported on the results of a pregnancy termination service set up as part of a National Health Service hospital. Four hundred and eighty-eight patients were involved; 433 or 89 per cent were 10 weeks or less and aborted by the suction method⁵²; the remainder were patients with pregnancies of longer duration, aborted by other methods. Among the early ones there were:

. . . no serious operative complications such as uterine perforation, nor any major post-operative haemorrhage, and none required any operative intervention.⁵³

Twenty-two patients, or 5.9 per cent, had retained products of conception, and this incidence was directly related to the experience and care of the operator; there was a rapid improvement with increasing experience.⁵⁴ Possible sepsis occurred among 5.1 per cent of these; four women required admission to hospital for treatment. The remainder, fifteen, had a doubtful diagnosis and responded quickly to antibiotics.

108. Those patients with pregnancies of longer duration experienced more complications: two hysterotomies were necessary with failure of amniocentesis; 53 per cent of the induction patients, or twenty-eight, required uterine evacuation under anaesthesia; two patients required a blood transfusion. There was one cervical tear which needed repair; and sepsis occurred in three patients. These complications, although fewer than cited in many earlier studies, are again an indication of the necessity for avoidance of delay in the performance of abortions.

The European experience

109. Eastern Europe has had long experience with legal abortion. Low reported morbidity in these countries is an indication of the advantages to be gained through experience. Beric et al.⁵⁵ reported on 62 620 early legal abortions performed during the period 1960 to 1971. D & C was used until 1969, when VA came into use. They compared the results of these methods of performing abortions with those of 20 308 'other' abortions, both spontaneous and illegal, which came to their attention.

50. Stella C. Lewis, Shirley Lal, R. W. Beard, B. Branch, 'Outpatient termination of pregnancy', *British Medical Journal*, 4 December 1971, pp. 606-10.

51. M. G. R. Hull, Celia Gordon, R. W. Beard, 'The organisation and results of a pregnancy termination service in a national health service hospital', *Journal of Obstetrics and Gynaecology of the British Commonwealth* 81, 8 (1974), pp. 577-87.

52. Whenever possible dilatation of the cervix was avoided, *ibid.*, p. 579.

53. *ibid.*, p. 582.

54. *ibid.*, p. 584.

55. Beric et al., 1975, pp. 813-21. The study takes in all abortion patients in Novi Sad, Yugoslavia, during the period 1960-71.

Table IV.P.17

| | | Comparative morbidity rate per 100 abortions | | | | |
|--------|----------------------|--|----------------------|---|--------------------|----------------------|
| | | Perforations and cervical lacerations | Retained products | Secondary haemorrhage over 200 ml | Local infection | General infection |
| Legal: | D & C | 0.11 | 3.8 | { 3.4 | 0.3 | None |
| | VA | 0.05 | 1.3 | | | |
| Other: | Spontaneous (90%) | { 0.19 | n.k. | 18.3 | 0.7 | None |
| | Illegal (10%) | | | 80.0 | 3.6 | 6.3 |

Source: Beric et al., 'Accidents and sequelae of medical abortions', *Am. J. O and G* 116, 6 (1975), p. 818.

110. Thus it can be seen that the VA method incurs lower morbidity in both the areas of physical damage and retention of uterine products. The authors add:

. . . retention of ovular and placental tissue is more frequent in patients in whom the pregnancy had been of longer duration and when the operator was less experienced, had not taken adequate precautions, and was in a hurry. Of definite importance, also, are the operative techniques used and any abnormalities of the uterus.

Table IV.P.17 does not take into account primary haemorrhage, as a special study of this factor was made for a smaller group of patients. The authors summarise their findings.

A study of the blood loss (in millilitres) and duration of the operation was made in 2082 patients. It was found that the mean loss of blood with the D & C method ranged from 30 to 365 ml, from the fifth through the twelfth week of gestation. With the VA method, the range was 30 to 200 ml . . . The duration of the operation was shorter by the VA method (40 to 340 seconds), and was longest with the D & C method (190 to 780 seconds).⁵⁶

Again the VA method appears to be safer and quicker. It should be added that antibiotics are routinely administered to all patients, which would in part account for the low infection rates. But medical people differ as to the necessity or desirability of this practice.

111. Another large-scale Yugoslav study, this time in Ljubljana, has also attempted to ascertain the comparative differences in outcome with curettage and vacuum aspiration. The Ljubljana abortion study⁵⁷ was conducted during the period 1971 and 1972 under the auspices of the Yugoslavian-American co-operative Medical Research Program.

112. The study group included 4733 patients, with smaller numbers studied for various sequelae. They were divided into two groups by random allocation according to whether the last digit in the patient's birth year was odd or even. Staff evaluating post-operative sequelae did not know which method had been used for each patient.

113. Findings of the study included:

(a) *Anaesthetic complications*

3.3 per cent of the patients experienced some side effects from the anaesthetic. There was no difference by method.

⁵⁶ *ibid.*, p. 817.

⁵⁷ Dr L. Andolsek (ed.), *The Ljubljana abortion study, 1971-73* (National Institute of Health, Centre for Population Research, Bethesda, Maryland, USA, 1974).

Immediate haemorrhage

The study found 5 per cent of the patients with heavy bleeding, described as more than 300 ml. There were more patients in the D & C group than in the VA group—with the highest percentage found in the VA group needing additional curettage. Only one transfusion was required in the 4733 cases, and this patient had an already existing medical condition which required hysterectomy. Blood loss was heaviest after 10 weeks, regardless of the method used.

(b) *Perforations of the uterus*

In the 4733 induced abortions there were three diagnosed and confirmed perforations, 0.06 per cent, and one suspected.

All perforations occurred in the D & C group during dilatation, suggesting that the instruments producing the perforations were Hegar dilators. In all cases the operators were senior gynaecologists.⁵⁸

Experience of the operators was a crucial factor in complication rates. Operators who performed fewer than 100 abortions during the 2-year period had more injuries (0.92 per cent) than did those who performed between two and three hundred procedures (0.41 per cent). Complications were found to be related both to experience of the operator and fatigue if the operator had been over-scheduled.

(c) *Injuries to the cervix*

There were thirty-three cases of injuries to the cervix or 0.7 per cent; no difference was noted by method. It must again be noted that Hegar dilators, now being increasingly discarded by careful physicians, would have been a factor in these injuries.

Infections requiring rehospitalisation

Pelvic infections were noted in 1.2 per cent (28) of the D & C patients; 0.6 per cent (14) of the VA patients.

114. The study cites the following factors as influencing abortion complications:

- (a) health of the patient at the time of the procedure;
- (b) number of previous pregnancies;
- (c) duration of the pregnancy;
- (d) patient response to anaesthetic;
- (e) method used;
- (f) technical skill of the operator.

115. As a result of this study, the authors made the following recommendations:

Vacuum aspiration (VA) is better than curettage for abortion because it is quicker, has a lower perforation rate, induces less blood loss at operation, and involves less subsequent infections which require rehospitalisation . . . Our study showed that VA should be performed within the first 10 weeks of pregnancy. In more advanced pregnancies, additional curettage as a second procedure is often necessary.⁵⁹

Other findings from the Ljubljana study will be examined in the section on long-term sequelae.

116. A Polish study which investigated complications in a series of 5018 legal abortions found that:

58. *ibid.*, p. 15.

59. *ibid.*, p. 15.

The most frequent and dangerous immediate complication—perforation of the uterus—was made in almost all cases with the Hegar dilators.⁶⁰

There were twelve cases of perforation of the uterus.

117. In Hungary Czeizel et al.⁶¹ reported on 1 816 429 cases of legal abortion carried out between the years 1960 and 1969. All took place in hospital, 95 per cent before the 12th week of pregnancy. The method used was primarily D & C, which may account in part for the higher rate of morbidity encountered, in accordance with the findings of the Yugoslavian studies.

118. From the register of the Hungarian Ministry of Health, complications were recorded as follows: the perforation rate was 0.12 per cent or about the same as the Ljubljana study for D & C; the rate of primary haemorrhage was 1.6 per cent; inflammatory disease 0.87 per cent.

119. The authors' own series indicated what they believed was a small percentage of under-reporting in the above series in that their findings were as follows: the perforation rate was 0.08 per cent; abnormal haemorrhage 2.3 per cent; inflammatory disease 1.8 per cent. The overall incidence of early complications was 41.58 per 1000, or 1 in 25 cases.

120. The authors concluded:

... these figures seem to show that legalisation of interruption of pregnancy considerably decreases mortality and morbidity.

The Australian experience

121. Legally induced abortion is still a fairly recent procedure in this country, and some of the early studies reflect this inexperience. Professor Carl Wood has commented on the difference in morbidity rates in hospital teaching units 'where a large number of people do a small number of abortions' and the clinics, where experienced operators perform numerous abortions with little morbidity. 'There is no doubt that people who do a large number of abortions do them better.'⁶²

122. This observation has been illustrated in the Eastern European studies above and is amply substantiated by comparative results from Australian experience.

123. Dr Miller's study⁶³ of morbidity in association with abortions carried out in the Royal Adelaide Hospital is similar to Stallworthy's in both the results obtained and in the reasons for the results.

124. Miller found significant complications in 170 out of 349 patients, or 49 per cent. More than half the operations were performed by specialists.⁶⁴ This disturbingly high rate was incurred for the following reasons:

- (a) There was a high percentage of concurrent abdominal sterilisation, 23 per cent or 80 patients.
- (b) A percentage of patients had pre-existing illnesses.

60. F. Glenc, 'Early and late complications after therapeutic abortion', *American Journal of Obstetrics and Gynaecology* 118, 1 (1974), p. 34.

61. A. Czeizel and Z. Bogнар, 'Mortality and morbidity of legal abortion', *Lancet*, 24 July 1971, pp. 209-10.

62. C. Wood, *Medical Journal of Australia*, 24 August 1974, p. 293.

63. J. M. Miller, 'Medical abortion in South Australia: a critical assessment of early complications', *Medical Journal of Australia*, 28 April 1973, pp. 825-30.

64. *ibid.*, p. 827.

- (c) Nineteen per cent of the patients (66) underwent hysterotomy, some of them in the first trimester of pregnancy.
- (d) One per cent of the patients (4) experienced hysterectomy.
- (e) The suction method was used much later in the pregnancy than is now considered good practice, even till past 14 weeks⁶⁵ (23 cases in the latter category).
- (f) Approximately 9 per cent of the patients (31) were left with products of the conceptus after the procedure, which in turn led to fever, haemorrhage, infections and the necessity for repeat curettage.
- (g) The perforation rate was approximately 1 per 100, the cervical laceration a little higher. These results are caused by inexperience with the method, or using vaginal methods too late.
- (h) The excessive bleeding in 73 patients, or over 20 per cent, was also caused by using the wrong methods for the stage of pregnancy, and by inexperience; 62 patients required transfusion (8 had pre-existent anaemia), approximately 18 per cent.

125. The 15 per cent post-operative fever risk cited by Miller is comparatively high. And contrary to the findings in other studies, there was no improvement in these complication rates in the second year. These results may possibly be due to many people doing few abortions.

126. Miller's other study⁶⁶ reveals similar problems. In the same 2 years, seven gynaecologists performed 390 abortions. Eighteen per cent (70) of the patients underwent hysterotomy, 4.5 per cent (18) hysterectomy. Almost one-third of the patients were sterilised in association with the abortion procedures, and eight cases had other additional operations. The reporting does not appear to be complete, as Miller rightly surmises—more patients were reported as requiring transfusion than had excess bleeding, and retained products. It is therefore not a useful study, except as an unfortunate indication of the numbers of abdominal operations and sterilisation procedures then being performed.

127. Aileen Connon's report⁶⁷ on the experience with abortion in the other two teaching hospitals in Adelaide is somewhat less disturbing. She reported on 582 cases of induced abortion performed in 1970, or shortly after legalisation. She reported 18.6 per cent morbidity in contrast to Miller's 49 per cent at the Royal Adelaide Hospital. But again there was a 23 per cent incidence of hysterotomy and almost 26 per cent were sterilised; 8 per cent of the patients were ill enough to be aborted on medical grounds.

128. Twenty-eight patients, or 4.8 per cent, experienced post-operative fever; twenty-five or 4.3 per cent lost more than 500 ml of blood, seventeen of whom needed transfusion; seven, or approximately 1 per cent, needed a re-evacuation procedure.

129. Dr Connon's second report dealt with the second year of legalised abortion as it occurred in the Queen Victoria and Queen Elizabeth Hospitals of South Australia.⁶⁸ Among 638 cases, there was an overall complication rate of 9 per cent, almost a halving of the rate from the previous year.

65. Miller himself declares: 'Suction after 10 to 12 weeks gestation should be undertaken with considerable reservation', p. 829.

66. J. M. Miller, 'Therapeutic termination of pregnancy in private practice', *Medical Journal of Australia*, 28 April 1973, pp. 831-4.

67. A. F. Connon, 'Medical abortion in South Australia; the first twelve months under new legislation', *Medical Journal of Australia*, 18 September 1971, pp. 608-14.

68. A. F. Connon, 'Trends in legalised abortion in South Australia', *Medical Journal of Australia*, 3 February 1973, pp. 231-4.

The commonest post-operative complications in the present series were significant fever and retained products of conception necessitating a second general anaesthetic and repeat evacuation of placental products from the uterus.⁶⁹

We can predict that this complication will decrease further with experience. However, it should be noted that the teaching hospitals are not performing enough abortions to become really skilful at this procedure, and will therefore generally be likely to find higher morbidity in their abortion patients than will the clinics which handle numerous patients.

130. There was a reduction in the number of hysterotomies reported by Connon, 23 per cent in the first series, 8 per cent in the second, reflecting an increased reluctance to perform hysterotomy, and an improvement in processing abortion requests to avoid delay. Connon also recommends that D & C be replaced by VA and that abortions be performed as early as possible.⁷⁰

131. Table IV.P.18 summarises the South Australian experience by percentages:

Table IV.P.18

| | Royal Adelaide | Queen Elizabeth | | |
|------------------------------------|-------------------|-----------------|---------|---------|
| | 1970-71 | 1970 | 1973-74 | 1974-75 |
| | % | % | % | % |
| No complications | 51 | 81.5 | 95 | 97.6 |
| Temperature rise | 14.6 | 8.1 | 3.0 | 1.2 |
| Blood loss* | 20.9 | 7.3 | 0 | 0 |
| Retained products | 8.9 | 2.0 | 1.3 | 1.2 |
| Perforation or tearing | 0.6 | 0.3 | 0.7 | 0 |
| Other | 6.0 | 0.7 | 0 | 0 |
| Complication rate | 49 | 18.5 | 5 | 2.4 |
| Number of subjects | 349 | 346 | 435 | 82 |
| Not indicated: | | | | |
| Gestation period | | | | |
| Method | | | | |
| Pre-existing medical complications | | | | |
| Sterilisation | | | | |

* The amount reported in the studies varied from 200 to 750 ml.

Source: Compiled from cited publications and Exhibit 92 (b).

132. Another Australian study illustrates the reduction in morbidity when abortion is treated as a specialised procedure with continued assessment to decrease the likelihood of complications. Dr L. P. Lang of the Royal Newcastle Hospital found no significant morbidity in 203 patients he treated on an outpatient basis.⁷¹ There were no perforations or cervical lacerations, and no blood loss over 200 ml. The only complication worthy of reporting was infection, found to be mild in ten, or 5 per cent, of the patients, and moderate in eleven, or 5.5 per cent, of the patients. Two of these were admitted to hospital. All responded rapidly to antibiotics. The second patient in the series had an incomplete abortion which required a second re-evacuation by suction curette on an inpatient basis. There was no recurrence of this event, as 'since then, all

69. *ibid.*, p. 233.

70. *ibid.*, p. 234.

71. L. P. Lang, 'Outpatient termination of pregnancy', *Medical Journal of Australia*, 20 April 1974, pp. 611-13.

products [were] inspected after suction and no case of incomplete tissue removal has occurred'.⁷² The complication rate for this series is probably 1.5 per cent or three cases in 203. But these are not significant complications.

133. Dr Stella Lewis, of the Queen Elizabeth Hospital, Adelaide, in a paper in preparation for publication, declares that the early UK and Australian studies are:

. . . unreliable for comparison since they are not based on standardised techniques and may reflect the varying experience of occasional operators having mixed attitudes to abortions which were performed at the end of routine gynaecological lists. Rigid instruments had been used almost exclusively . . . The lowering of complication rates associated with abortion is not part of the natural history of the use of this operation. Experience has shown that improvement is related to organisation, standardisation of techniques, preclusion of operators who are ambivalent about performing such procedures and the geographic separation of the working area from the remainder of the hospital.

The Commission Australian morbidity survey

134. After examining the available Australian data, the Commission decided that there was a definite need for clearly defined, up-to-date morbidity data. The co-operation of eight medical facilities was sought and a questionnaire filled out for all abortion patients during a 6-week period. Included in the study were three public hospitals, three clinics, and two private hospitals—all located in three of the major centres in Australia.

[Further details of the study appear in Annexe IV.Q. The full results were not available in time to include in this report.]

135. A recent submission from the Australian Council of the Royal College of Obstetricians and Gynaecologists presents overall findings for 1971–73:

. . . in the 3 years no death has been reported due to abortion alone. The reported sepsis and haemorrhage rate is between 1 and 2 per cent for each.⁷³

The Council, however, expresses doubt as to whether this was the true incidence of complications.

136. The Commission study indicates that, at least for those facilities who participated in our survey, there were no deaths. The complication rate at the time of the procedure was:

| | No. | % |
|------------------------|-----|-----|
| Cervical tearing | 0 | 0 |
| Perforation: reported | 4 | 0.1 |
| suspected | 4 | 0.1 |
| Blood loss over 301 ml | 17 | 0.6 |

72. *ibid.*, p. 612.

73. Submission 1246, RCOG, Aust. Council. There has, however, been one death reported in South Australia in the year 1976. This, however, was not directly attributable to an abortion procedure:

I would advise that the Committee determined that this death, recorded as an abortion death as a result of post-operative complications, should be accompanied by a supportive statement indicating that it was considered to be directly attributable to the administering of an anaesthetic, the anaesthetic being maintained following the completion of the abortion procedure in order to undertake a further planned sterilisation operation.

Commission correspondence, Sir Leonard Mallen, 10 December 1976.

The New Zealand experience

137. Recent data from New Zealand⁷⁴ report on comparative morbidity found in the Auckland Medical Aid Centre and the National Womens Hospital. The Centre, a clinic, performed 1874 abortions in its first year; National Womens Hospital had 201 cases in the same period. Table IV.P.19 analyses the early complications from both facilities.

Table IV.P.19

| Complication | Auckland Medical Aid Centre | | | National Womens Hospital | | |
|---------------------|-----------------------------|-----------------|-------------------|--------------------------|-----------------|-------------------|
| | No. | % complications | % total abortions | No. | % complications | % total abortions |
| Uterine perforation | 7 | 26.9 | 0.4 | 5 | 29.4 | 2.4 |
| Incomplete abortion | 8 | 30.8 | 0.4 | 4 | 23.5 | 2.0 |
| Pelvic sepsis | 10 | 38.5 | 0.5 | 2 | 11.8 | 1.0 |
| Other | 1 ^(a) | 3.8 | 0.05 | 6 ^(b) | 35.3 | 3.0 |
| Total | 26 | 100 | 1.35 | 17 | 100 | 8.4 |

(a) Undiagnosed pain

(b) Pyrexia without obvious pelvic sepsis.

Source: M.A.H. Baird, 'Morbidity of therapeutic abortion in Auckland', *NZ Medical Journal*, 9 June 1976, pp. 395-8.

Twenty-six women (1.4 per cent) required hospitalisation following complications incurred at the Auckland Medical Aid Centre; seventeen women (8.4 per cent) of those terminated at the National Womens Hospital had significant complications.

138. In part, the difference in complication rates was caused by the fact that all the AMAC patients were in the first trimester of pregnancy, and that VA was the method used. At National Womens forty-three cases, or approximately one-fifth of the patients, were in the second trimester. None of the AMAC patients required a major operation; four of the National Womens Hospital patients underwent laparotomy.

Summary of some evidence for skill and experience of the operator as the major factor influencing morbidity

139. Malcolm Potts, director of the International Planned Parenthood Federation, has said that:

The task of emptying a pregnant uterus is relatively simple. Performed with moderate skill and with appreciation of the problems involved the procedure can have a high degree of safety, but performed by unskilled people it presents considerable dangers . . . Induced abortion is one of the commonest surgical procedures undertaken in the world today and is unique in that the majority of practitioners are unskilled and frequently working outside the law.⁷⁵

74. M.A.H. Baird, 'Morbidity of therapeutic abortion in Auckland', *New Zealand Medical Journal*, 9 June 1976, pp. 395-8.

75. M. Potts, in I. R. Nazar (ed.), *Induced abortion: a hazard to one's health?* (proceedings of the first conference of the International Planned Parenthood Federation, Beirut, 1971).

This is to state obliquely that, unfortunately, many working within the law are also unskilled. But the question of skill and experience comes to bear on any surgical procedure. The following is a discussion of this as it relates to sterilisation using the newer laparoscopic technique:

The important factor in laparoscopic complications is the experience of the operator. Many US studies and the 1974 report of the Medical Defence Union of Great Britain have shown that most mistakes occur during the first twenty laparoscopies attempted by the surgeon, irrespective of his clinical status or surgical skills. The adage of 'see one; do one; teach one' is lethal and has been largely responsible for the bad experience of this method in Great Britain in particular . . . one is not a competent laparoscopist until at least 100 procedures have been carried out . . . a threefold increase in failures was found among those operators doing their first 100 cases.⁷⁶

Everything said of laparoscopy in this quotation applies also to abortion procedures. Unfortunately, the increasing demand for legal abortion as women switch from illegal to legal abortion often places them in the hands of operators relatively inexperienced in performing abortions, as the medical profession attempts to cope with the new demand. The high morbidity in association with induced abortion at a stage of inexperience is exemplified in the findings of Stallworthy in the UK and Miller in Australia. Similar high morbidity would also be found in the early stages of laparoscopy operations and others; but these results are not used in partisan debates, and the public is not informed of them.

140. When placing oneself in the hands of a surgeon or other qualified practitioner, one assumes that highly skilled care will follow. Unfortunately, this is not always so, and the history of medicine is a history of trial and error, progress and mistakes, learning and experience, as is every human endeavour. The abortion procedure involves additional motivational problems. It is a common human characteristic that those highly motivated in a specialist area within their professional competence are likely to develop a high level of skill. The moral dilemma involved in abortion may affect this level of motivation; thus the level of skill may also vary.

141. The following studies present evidence that the skill, motivation and experience of medical practitioners will influence morbidity rates.

142. Hull et al. examined their records to relate morbidity to the experience of the operator, and found a significant relationship as the months went by. Morbidity dropped rapidly by the second month, but would rise again when the operators 'perhaps became less careful in their technique'.⁷⁷ This conforms to the Ljubljana findings which found significant differences with experience, and also a slightly increasing morbidity if their operators were over-scheduled.⁷⁸ Table IV.P.20 from the Ljubljana study illustrates the significance of experience.

From data obtained for each operator a conclusion can be drawn that operators who performed less than 100 abortions during the 2-year period had more injuries (0.92 per cent) than did those who performed between 200 and 300 procedures (0.41 per cent). Operators who performed more than 300 operations had a higher percentage of injuries (0.71 per cent), suggesting they may have been over-scheduled.

143. In Australia, Dr Lang's Newcastle study indicates a high degree of care and motivation to reduce complications. When a problem was noted, he took steps to prevent a recurrence even though this entailed a great deal more time and trouble to him. His results perhaps represent an ideal situation.

76. John Leeton, 'Recent advances in female sterilisation', *Australian Family Physician* 5 (1976), p. 190.

77. Hull et al., p. 584.

78. Andolsek, p. 13.

Table IV.P.20 Operators and uterine injury by training

| Operator | No. of operations | % of total | No. of injuries | % |
|----------|-------------------|------------|-----------------|------|
| Senior | 3161 | 66.8 | 26 | 0.82 |
| Junior | 1572 | 33.2 | 7 | 0.45 |
| Total | 4733 | 100.0 | 33 | 0.70 |

Source: L. Andolsek, *The Ljubljana abortion study, 1971-73*, (National Institute of Health, Centre for Population Research, Bethesda, Maryland, 1974), p. 13.

144. The JPSA report found also that, particularly in the area of retention of uterine products which is the main cause of subsequent haemorrhage and infection, the physician is able to control this problem by careful procedures.

Complication rates for abortions by suction declined approximately 50 per cent from the third quarter of 1970 to the second quarter of 1971.⁷⁹

145. The Hodgson Preterm study found that damage was reduced with time; the rate of perforations, already low, was almost halved in the second thousand patients. Dr Hodgson also advocates better post-operative care to facilitate treatment for any complications which may arise. This improved care will come only when women have ready access to abortion facilities near their own homes.

146. Based on his own series, Frank Novak discusses the role of skill and experience in relation to the question of retention of uterine products and finds a direct relationship between incidence and skill.⁸⁰

147. Lewis et al.⁸¹ found that 'post-operative complications declined sharply between groups 1 and 2 and a further decline occurred between groups 2 and 3' as operators gained experience.

148. McDonald and Aaro summed up the situation after the US Supreme Court decision legalising abortion:

We can expect the highest mortality, morbidity, and complication rates during the next years because this has been the pattern for all nations as they have gained experience during the first years after abortion was legalised.⁸²

It is important to keep in mind that all medical procedures have high rates of associated difficulties in their early stages, and that there is no unalterable complication rate with any procedure. It will be dependent upon many factors such as skill and experience (which may be affected by motivation), stage of medical technology, and level of surgical hygiene maintained—as well as on all the variations in individual patients.

79. Tietze and Lewis, *Studies in Family Planning* 3, 6 (1972), p. 98, reporting on the JPSA, and see table 33, p. 119.

80. F. Novak, 'Experience with suction curettage' in R. Hall (ed.), *Abortion in a changing world* (Columbia University Press, New York, 1970), pp. 78-9.

81. Lewis et al., p. 608.

82. Thomas W. McDonald and Leonard A. Aaro, 'Medical complications of induced abortions', *Southern Medical Journal* 67, 5 (1974), pp. 560-6.

Sterilisation and abortion

149. The early stages of legalised abortion practice record a higher rate of associated sterilisation than the later stages. This is particularly true of the UK and Australia. The higher rates do not always appear to reflect the wishes of the women involved, but may be in part due to the wishes of providers. Women may request sterilisation thinking it will improve their chances of getting an abortion.

150. Whatever the motives, the high incidence of associated sterilisation has resulted in unnecessary mortality and morbidity, and an undetermined amount of subsequent anguish to the women involved.

151. Sterilisation in the USA was found to increase the likelihood of complications as much as ten times. In the UK the risk of death was increased tenfold if the abortion was accompanied by sterilisation.⁸³ UK morbidity figures do not often indicate when abortion has been associated with sterilisation, but it is likely that morbidity was also significantly increased. Stallworthy's series indicates that nearly 18 per cent of the patients were sterilised.

152. Australian figures also do not relate complications to associated sterilisation, but some of the high morbidity found in the early stages of legalisation must be attributable to the high numbers of women sterilised. In Miller's first series⁸⁴ 23 per cent of 349 patients (78) were sterilised (by laparotomy). In his second series⁸⁵ 29 per cent (115 of 390 cases) were sterilised. Connon's first series⁸⁶ involved 23.6 per cent sterilisation, with 21.5 per cent in her second series.⁸⁷

153. In the Commission's 1976 morbidity survey, 58 or 2.1 per cent were sterilised in association with abortion, which may in part account for the low complication rates achieved.

154. There have been no studies of psychological sequelae following sterilisation with abortion in Australia but evidence from other countries indicates that it is important for a woman's mental health that she not be pressured into making two serious decisions at the same time, particularly in a time of distress (see paragraph 258).

Menstrual regulation

155. A recent method of post-conception fertility control is known as 'menstrual regulation', also 'menstrual extraction' or 'interception of pregnancy'. It is increasingly used to induce a delayed period, before a suspected pregnancy has been confirmed, on the grounds that it is then a safer procedure. Also, for those women who regard an unwanted pregnancy as a crisis, it would save them several weeks of anxiety.

156. Suction is used to evacuate the uterus, but little or no dilatation of the cervix is necessary at this stage. One study analysed the morbidity in association with the method.⁸⁸ Stringer et al. followed up 424 patients undergoing menstrual extraction in three London teaching hospitals, and found a low incidence of serious complications; 2.8 per cent of the patients experienced retained products; 2.6 per cent were found to be still pregnant after the procedure; 3.4 per cent experienced a rise in temperature.

83. Lane report, vol. I, p. 45.

84. Miller, *Medical Journal of Australia*, 28 April 1973, p. 827.

85. *ibid.*, p. 832.

86. Connon, *Medical Journal of Australia*, 18 September 1971, p. 611.

87. Connon, *Medical Journal of Australia*, 3 February 1973, p. 232.

88. J. Stringer, M. Anderson, R. W. Beard, D. V. I. Fairweather and S. J. Steele, 'Very early termination of pregnancy (menstrual extraction)', *British Medical Journal*, 5 July 1975, pp. 7-9.

There were no haemorrhages, no perforations or cervical tearing, and no deaths. Ninety per cent of the patients had been no more than 14 days overdue with their periods, and of these, 67 per cent proved to be pregnant. Long-term damage is unlikely in that there is little or no dilatation of the cervix involved.

Morbidity of childbirth

157. By way of comparison with abortion morbidity figures, Professor Rodney Shearman reports that 20 per cent or more of spontaneous full-term births incur complications.⁸⁹

Long-term sequelae of induced abortion

Difficulties in assessment

Former obstetric history

158. If a patient's former obstetric history is compiled from hospital records, that is in the context of a historical-prospective study, there is a good chance of accuracy, although there is always the possibility of former or intervening illicit abortions or illnesses which do not appear on these records. But most studies rely on patient recall and patient reporting of past obstetric history, which may be unreliable, either unintentionally through forgetfulness, or intentionally through reluctance to admit criminal abortion. There is therefore the possibility that patients who have not admitted to former induced abortion will appear in studies as part of control groups compared with groups of women who *have* admitted to prior induced abortions. This would prejudice the study against the finding of long-term sequelae in the study group. On the other hand, several studies have shown that patients who subsequently develop difficulties will more readily admit to past induced abortions than others⁹⁰, which would more heavily weight the findings in the direction of post-abortion difficulties. Only long-term prospective studies in a situation where abortion is available without stigma can fairly shed light on this problem. The present World Health Organisation study should prove to be of considerable assistance when findings are published in 1977.

Legality or illegality of prior abortion

159. With illegal abortion there is a significantly higher risk of morbidity; records of hospital admissions in areas where abortion is or has been restricted are a reliable index of this fact. The high infection rates, particularly with salpingitis which affects the fallopian tubes, may have some influence on subsequent fertility and ectopic pregnancy. Also cervical damage is more likely with illegal abortion, with a subsequent increase in cervical incompetence in future pregnancies. The latter risk will also be present in some measure where abortion is restricted and experience of practitioners is minimal.

89. *Sydney Morning Herald*, 31 May 1976. This figure has since been confirmed by Professor Shearman (personal communication). It must be kept in mind that much of the difficulty in assessing complications of abortion is present in assessing childbirth.

90. Carol J. Hogue, 'Low birth weight subsequent to induced abortion', *AmJOG*, 1 December 1975, pp. 675-81.

Susan Harlap, A. Michael Davies, 'Late sequelae of induced abortion: complications and outcome of pregnancy and labor', *Am J Epidemiology* 102, 3 (1975), pp. 217-24.

Lewis H. Roht, Hideyasu Aoyama, 'Induced abortion and its sequelae: prevalence and associations with the outcome of pregnancy', *Int J Epidemiology* 2, 1, pp. 103-13.

Reasons prior abortion was performed

160. When abortion was restricted to those with medically therapeutic indications, these reasons might in themselves affect future fertility or future pregnancies, e.g. pelvic infections and metabolic disorders may be associated with future sterility and other obstetric problems.

Intervening obstetric circumstances

161. Intervening pregnancies or gynaecological illnesses must be taken into account. Short birth intervals are particularly likely to cause trouble in ensuing pregnancies⁹¹, both to mothers and infants. The length of the interval between abortion and subsequent conception may also be relevant.

Pregnancy and its sequelae

162. It must be borne in mind that pregnancy carries its own morbidity and risk to neonates, and that some pregnancies leave undesirable consequences in their wake. For example, caesarian sections, necessary in 5 per cent of births, will carry greater risks for subsequent births than would the majority of legal abortions.

Methods, gestation period and skill of operator

163. These are factors not generally taken into account in studies of prior induced abortions. Abortion in early pregnancy carries a low risk of morbidity and is likely to incur fewer long-term sequelae than later abortions. Vacuum aspiration, which necessitates less dilatation of the cervix than dilatation and curettage, is less likely to cause damage to the cervix. Experienced operators will cause less damage to the cervix than will inexperienced operators.

Matching of variables

164. Factors which influence outcome of pregnancies are age, parity, socio-economic circumstances, quality of diet and ante-natal care, and smoking. For example, the age distribution of those seeking abortion is weighted towards the young unmarried and the older high parity women, both of whom are predisposed to experience more difficulty in pregnancy and with their infants than other groups.

Standardisation or changes in definitions

165. Recent changes in definition or weight limits in describing premature births may be responsible for some apparent changes in prematurity rates. Also, some births registered as premature and/or stillborn are in fact the results of illegal interference, either earlier in the pregnancy or prior to presentation at the hospital for delivery. This incidence cannot be known. There are also practical reasons, such as the introduction of child payments, which may encourage a change in recording an infant which survives only briefly as liveborn, rather than stillborn or as a late spontaneous abortion.

Improvements in diagnosis

166. Recent improvements in the technique of diagnosing ectopic pregnancies may be a possible factor where increased incidence has been noted.

91. E. Seigel and N. M. Morris, 'Family planning: its health rationale', *AmJOG* 118 (1974), p. 995. Increased family size and short birth intervals are associated with increased maternal, infant and foetal deaths, higher prematurity rates, increased incidence of infectious diseases in both parents and children and other negative sequelae.

Conflicting results of present studies

167. There is little agreement in presently available studies. Some will find an increase in certain problems; others a decrease. Some will find one particular problem in a study group, but no occurrence of the particular problem others have found. For the time being one must conclude that all the above-mentioned difficulties make it unlikely that all relevant variables have been considered in most studies.

Studies available and their findings

168. A Greek study⁹² of 13 242 women admitted for delivery in a 2-year period in Athens found that, of 8312 whose pregnancy was not the first, 29 per cent admitted to one or more induced abortions. It was found that among these women with previous abortions, both induced and spontaneous, the percentage of stillbirths and premature births was double that of the control group—17 per cent and 8 per cent respectively.

169. Methodological shortcomings include the fact that abortion is illegal in Greece, which would increase morbidity in association with these abortions; obstetric history may be subject to incorrect recall by the patients themselves; the study was not adequately controlled for either number of prior births or the pregnancy order; it is unclear as to whether the study includes data on spontaneous abortions with the data on induced abortions; method of termination has not been identified; the patients were not controlled for many of the other relevant variables.

170. Harlap and Davies⁹³ conducted a prospective study of 11 057 pregnancies in Jerusalem. Among the 752 mothers who reported one or more induced abortions, more of them reported bleeding in the first trimester of the pregnancy than others; they were less likely to have a normal delivery; the risk of early neonatal death was doubled; late neonatal death was three to four times as likely; there were increases in major and minor congenital malformations. The authors, however, noted that induced abortion is correlated with several factors which could have influenced such outcomes: smoking, maternal age, increasing birth order, membership in certain ethnic groups.

Some of these variables themselves affect the chances of an unfavourable pregnancy outcome and must be taken into account in estimation of the risks associated with previous induced abortion.

171. Induced abortion is still illegal in Israel in most cases, although a percentage of women obtain it under good medical conditions regardless. But it cannot be determined what percentage in this study group has experienced illegal abortion under unfavourable conditions. 'There is no reason to fear that liberalised abortion practices will be followed by a large increase in the rates of neonatal deaths or prematurity'.⁹⁴ The authors comment that:

. . . for the unmarried woman, the very young and the poor, the small increased risk for subsequent pregnancies is likely to be outweighed by the undesirable consequences of letting the pregnancy continue.⁹⁵

They, however, uphold the theory that forcible dilatation of the cervix may be a factor in subsequent birth problems.

92. Stefanos N. Pantelakis, George C. Papadimitriou, Spyros A. Doxiadia, 'Influence of induced and spontaneous abortions on the outcome of subsequent pregnancies', *AmJOG* 116, 6 (1973), pp. 797-805.

93. Harlap and Davies, 1975, p. 218.

94. *ibid.*, p. 222.

95. *ibid.*, p. 222.

172. Wright et al.⁹⁶ found a tenfold increase in the incidence of second trimester spontaneous abortion after former termination of pregnancy. In a study group of ninety-one patients booked in for delivery compared with a control group of ninety-one patients without previous induced abortion, the former group had eight spontaneous abortions and one clinically incompetent cervix requiring suture, and the latter one spontaneous abortion. In contrast to other studies, Wright et al. found 'no increased incidence of premature labour or other complications of pregnancy', which does not seem to be consistent with the theory that an incompetent cervix will cause premature births as well as spontaneous abortion. Perhaps the small sample of Wright's study is a factor in this. Other factors which may be relevant: only one of the former abortion cases had had an early procedure (the abortions had been performed in a period when vaginal termination was performed much later than is now accepted as good practice); patients were matched only for age, with other factors not taken into consideration; data were obtained from patient recall.

173. Roht and Aoyama⁹⁷ in a survey of 3475 Japanese women aged 20 to 44 found that over 40 per cent admitted to prior induced abortion. Their survey found that:

... maternal age-specific analysis showed that the outcomes of pregnancies subsequent to an induced abortion were qualitatively similar to the outcomes of pregnancies in women who did not use abortion.

Again, the study is subject to the correctness of patient recall, or their willingness to admit induced abortion and subsequent difficulties. Even in the comparatively permissive atmosphere surrounding abortion in Japan, it was found that women were slightly less likely to admit to prior abortion in the presence of an interviewer than they were through a postal survey.

174. A small study by Johnstone et al.⁹⁸ found significant correlations between previous abortion by vaginal methods and subsequent larger than average cervical diameters in pregnant women. This larger diameter does not necessarily imply cervical incompetence, but the authors believe a dilatation of 10 mm during induced abortion is the maximum desirable, to prevent such a possibility. They note that Stallworthy et al. used 'Hegar dilators larger than No. 12 in the majority of cases and larger than No. 14 in a fair number', which would account for their high laceration rate of 4.8 per cent. (See section on morbidity, para. 54ff.) Other studies with similar high laceration and haemorrhage rates also used vaginal methods in later than 12-week pregnancies.⁹⁹ I. S. Edwards agrees that Hegar dilators, which dilate quickly, may cause cervical damage 'while we persist with the use' of them.¹⁰⁰ The *Medical Journal of Australia* also recommends early termination and the use of tapered dilators rather than the Hegar dilator, for the same reasons. The same *MJA* also points out that cervical incompetence is rare and can occur with no previous history to account for it.¹⁰¹

175. In a sample of 397 patients followed up for 18 months or more subsequent to termination by prostaglandin induction (second trimester) Mostyn Embrey¹⁰² found eight patients with spontaneous abortion (five first trimester and three second). One

96. C.S.W. Wright, S. Campbell and J. Beazley, 'Second trimester abortion after vaginal termination of pregnancy', *Lancet*, 10 June 1972, pp. 1278-9.

97. L.H. Roht and H. Aoyama, 'Induced abortion and its sequelae: prevalence and associations with the outcome of pregnancy', *International Journal of Epidemiology* 2, 1 (1973), pp. 103-13.

98. F. D. Johnstone, R. J. Beard, I. E. Boyd, T. G. McCarthy, 'Cervical diameter after suction termination of pregnancy', *BMJ* 1 (1976), pp. 68-9.

99. Stallworthy et al., (1971), pp. 1245-9.

100. I. S. Edwards, letter, *MJA*, 7 October 1972, p. 350.

101. *MJA*, 29 December 1973, pp. 1135-6.

102. Mostyn P. Embrey, 'Prostaglandin-induced abortion and cervical incompetence', *BMJ*, 31 May 1975, p. 497.

of the eight had clinical evidence of cervical incompetence. This patient had had vaginal aspiration termination of a 14-weeks gestation pregnancy prior to the termination by prostaglandins, which again seems to be evidence that the cervix should not be over-dilated as would have occurred with a second trimester vaginal abortion. Of the other seven patients, those five who wished to have children followed up with normal term deliveries. Another twenty-six full-term deliveries with no obstetric or neonatal complications were found among the 397 patients.

176. Forster¹⁰³ in an article in the *MJA* also draws attention to the possibility of cervical trauma, particularly in the young nullipara. He is against even the use of no. 8 Hegar dilators for these patients, and recommends the use of other types of dilators. Forster had encountered seventy-one cases with a history of past criminal abortion by curettage, out of 300 patients experiencing spontaneous abortion. In his opinion, such spontaneous abortions, and premature labours, can be avoided by the insertion of a supporting ligature around the cervix. But the incidence of this problem should decrease as induced abortion is performed under good medical conditions with a greater awareness of the possibility of cervical trauma.

177. The European studies tend to be large samples based on long experience with early legal abortion. In Skopje, Yugoslavia, in 1972, a controlled study¹⁰⁴ was conducted by following up 948 women, 222 of whose first pregnancies had been terminated by induced abortion, and 726 of whom had experienced full-term delivery. Their subsequent pregnancies were analysed to determine the incidence of adverse outcomes.

No significant differences were found between first-pregnancy aborters and deliverers, for subsequent conception rates, spontaneous abortion or low birth rates.

178. The methodology for this study was sounder than most in that patient recall of past obstetric history was checked with both hospital records and with official abortion reports. With this system of cross-checks, the study revealed that 'reliance on patient recall is indeed risky. Selective recall could explain the results' found in other studies. It was found that past abortion is more readily recalled after an adverse pregnancy outcome than after a normal delivery. The author concluded that 'selective recall may affect results even if it is not as great as that found in this study'.¹⁰⁵ The groups were matched for pre-pregnant weight, education, age, income and smoking, as well as obstetric history. Smoking habits seemed to be the most significant differential.

179. In the large Yugoslavian study conducted by Beric et al.¹⁰⁶ a different methodology was used to ascertain whether or not induced abortion caused any adverse long-term sequelae. They compared the figures for their total numbers of various obstetric events to determine what changes had occurred over the years in relation to abortion practice. Table IV.P.21 illustrates the total numbers of patients treated at the Department of Obstetrics and Gynaecology of the University of Novi Sad between the years 1960 and 1970. The department serves a population of approximately 2 million. It was found that although the number of deliveries and legal abortions increased, the number of 'other' abortions, ectopic pregnancies and premature births overall declined. The authors do not believe that they can indicate any quantitative relationship between abortion and long-term sequelae.

103. Frank M. C. Forster, 'Abortion and the incompetent cervix', *MJA*, 28 October 1967, pp. 807-9.

104. Hogue, 1975, p. 675.

105. *ibid.*, p. 681.

106. Berislav M. Beric, Milan Kupresanin, 'Vacuum aspiration, using paracervical block for legal abortion as an outpatient procedure up to the 12th week of pregnancy', *Lancet*, 18 September 1971, p. 619.

Table IV.P.21 Total number of pregnancies dealt with by the Department of Obstetrics and Gynaecology, 1960-70

| Year | No. of deliveries | No. of abortions | | No. of ectopic pregnancies | % of prematurity |
|------|-------------------|------------------|-------|----------------------------|------------------|
| | | Legal | Other | | |
| 1960 | 2 279 | 4 580 | 2 890 | 148 | 7.45 |
| 1961 | 2 527 | 4 827 | 2 453 | 161 | 7.15 |
| 1962 | 2 406 | 4 754 | 1 864 | 140 | 8.34 |
| 1963 | 2 621 | 4 255 | 2 273 | 190 | 8.68 |
| 1964 | 3 001 | 5 045 | 1 473 | 165 | 10.52 |
| 1965 | 3 232 | 5 013 | 1 715 | 175 | 10.39 |
| 1966 | 3 282 | 4 572 | 1 405 | 166 | 8.36 |
| 1967 | 3 394 | 4 472 | 1 336 | 159 | 9.27 |
| 1968 | 3 394 | 5 672 | 1 442 | 157 | 8.73 |
| 1969 | 3 621 | 6 320 | 1 223 | 142 | 7.34 |
| 1970 | 3 813 | 6 445 | 1 058 | 121 | 7.12 |

Source: Berie et al., *Lancet*, 18 September 1971, p. 618.

180. The authors wish to emphasise that:

It is important to mention in this connection that our department is the only gynaecologic and obstetric hospital institution in the town and surrounding areas, and all cases of ectopic pregnancy, and deliveries as well, are admitted to our department.¹⁰⁷

181. In contrast to the Yugoslavian findings, a Hungarian study shows a rising incidence of placenta praevia and premature placental detachment. It was found that in the 1960s the premature birth rate in Hungary was the highest recorded in Europe.¹⁰⁸ Methodological difficulties with this study may include a change in recording procedures and a change in the definition of 'prematurity' which could have affected the figures in this manner. There is also a statistical problem in that there is a normal premature birth rate of 10 per cent. With numerous women terminating pregnancies, the statistical probability is increased per se when births do occur—that is numbers will increase, but not rates.¹⁰⁹

182. Malcolm Potts, medical director of the International Planned Parenthood Federation, believes that the reasons for the conflicting data in the Yugoslavian and Hungarian findings may lie in the methods used and care exercised:

The great majority of abortions in Hungary are done by dilatation and curettage under general anaesthesia. In my experience dilatation is usually rapid and up to 10 mm or more. It is notable that in an adjoining area of Yugoslavia where outpatient abortion under paracervical block has been used for over a decade there has been no alteration in the prematurity rate . . .

The use of the Karman catheter is becoming popular in many centres. With or without local anaesthesia, it would seem likely that this method does little insult to the cervix.¹¹⁰

183. A 1974 New York study¹¹¹ shows both a 50 per cent decline in the maternal mortality rate in New York City since legalisation and also 'an unexpectedly large decrease in the neonatal mortality rate'. The authors attribute this decline to a decrease in the number of late illegal interventions in pregnancies.

107. Beric et al., *AmJOG*, 1973, p. 819.

108. Czeizel & Bogнар, 1971.

109. James Trussell, 'Third thoughts on abortion', *British Journal of Hospital Medicine*, May 1973, p. 603.

110. Potts, letter, *BMJ*, 24 March 1973.

111. Leonard Glass, Hugh E. Evans, Donald P. Swartz, B. K. Rajegowda and Weiner LeBlanc, 'Effects of legalised abortion on neonatal mortality and obstetrical morbidity at Harlem Hospital Center', *Public Health Briefs, AJPH* 64, 7 (1974), pp. 717-8.

184. Another adverse finding comes from Greece where a group of researchers¹¹² found a significant increase in ectopic pregnancy. Of 5100 women admitted for reasons of pregnancy, there were sixteen cases of ectopic pregnancy. Another fourteen patients had experienced ectopic pregnancy in an earlier pregnancy. Of this total of thirty, four had no previous pregnancy; the remaining twenty-six were used for the study. These twenty-six patients were matched with three control groups for age, pregnancy order and husband's education. All of the patients were asked to report on the numbers of prior pregnancies which had terminated in induced and spontaneous abortions. The frequencies of these prior histories of abortion among ectopic patients was significantly higher than for the control groups. The authors estimate the risk of ectopic pregnancy to be tenfold following abortion.

185. Problems with this study are similar to others. The tendency to admit to prior abortion when difficulties arise, 'selective recall', would be likely to occur in Greece where abortion is illegal. The study may not in fact be relevant to legal abortion at all, as illegal abortion is known to carry far more risk of salpingitis than legal abortion. According to the authors:

To the extent that induced abortions predispose to tubal implantation through the mechanism of causing salpingitis, the circumstances of the operation would appear to have a bearing on the strength of the predisposing influence . . . abortions are illegal in Greece.¹¹³

It also seems likely that spontaneous and induced abortion have been treated alike in this study, although it is probable that many abortions reported as spontaneous are in fact the result of illegal intervention of some kind. The sample is also rather small for conclusive findings.

186. A 1970 Bulgarian study¹¹⁴ examined menstrual disturbances after legally induced abortion. Two groups of women were followed up for 2 years following the procedure. The first group of 148 women were aborted by dilatation and curettage; the second group of 100 underwent the vacuum aspiration method. The author found significant differences in the two groups. He found numerous instances of menstrual disturbances in the D & C group, but such disturbances after VA were infrequent and short-lived. The author therefore concludes that suction is less likely to cause trouble than abrasion of the uterus and recommends the use of the former method.

187. The Ljubljana abortion study looked at some long-term effects of induced abortion. Investigators found no evidence of menstrual disorders after induced abortion¹¹⁵, nor did they find evidence that the risk of ectopic pregnancy was increased.¹¹⁶ If anything, women with several induced abortions were found to be at slightly reduced risk of subsequent ectopic pregnancies.¹¹⁷ Tests to determine cervical incompetence, however, found five cases in 275, or a 1.8 per cent incidence of cervico-isthmic incompetence.¹¹⁸ It is possible this could have been avoided if Hegar dilators had not been used.

188. As has been noted in commenting on the studies to do with cervical trauma, the methods used appear to be a major factor in long-term sequelae. Just as a caesarian

112. Panayotis P. Panayotou, Dionysios B. Kaskarelis, Olli S. Miettinen, Dimitrios B. Trichopoulos, Anna K. Kalandidi, 'Induced abortion and ectopic pregnancy', *AmJOG* 114, 4 (1972), pp. 507-10.

113. *ibid.*, p. 510.

114. D. Andreev, 'Menstrual disturbances after interruption', *Folia Medica* XII, 4 (1970), pp. 263-8.

115. Andolsek, p. 32.

116. *ibid.*, pp. 36-7.

117. *ibid.*, p. 38.

118. *ibid.*, p. 41.

section delivery may cause difficulty in subsequent births, so may the practice of hysterotomy in induced abortion. Both Andrew Korda in the *MJA*¹¹⁹ and R. S. Ledwood in the *British Journal of Clinical Practice*, and many others, deplore the continuing use of abdominal methods with the availability of safer procedures:

The performance of hysterotomy in young women is a most undesirable and potentially hazardous procedure, and its performance . . . is totally unnecessary when the intra-amniotic injection of hypertonic solutions is so readily available and has low morbidity.¹²⁰

189. The most recently published findings¹²¹ report on a large sample of 26 000 consecutive births in six hospitals in Taiwan. Prior obstetric history was related to the incidence of difficulties with the present pregnancy. A study group of 1236 women experiencing prior abortion was matched for age, parity, previous stillbirths and/or miscarriages, and socio-economic status.¹²² Daling and Emanuel found that prior induced abortion was not a significant factor but that the socio-economic variable was crucial. It correlated significantly with prematurity, low birth weight, and foetal and early neonatal mortality. They also found that some women are at high risk for some types of abnormal pregnancy due to age, parity and history of previous abnormal outcome. Again the study is dependent upon the patient's own account of her prior history. Also abortion is not on paper legal in Taiwan, but is quasi-legal in that it is commonly performed by physicians using D & C. Another oddity appears to be the factor used as a socio-economic measure—hospital room cost. This must, however, have been a significant index in Taiwan as the factor was found to be crucial in influencing the findings.

190. The authors believe that confounding maternal variables must be taken into account. When they did not include these, 'significant relationships were found between previous abortion and various problems of outcome of subsequent pregnancies'. When they did include them 'all such relationships disappeared'.¹²³

191. The following figures¹²⁴ give some trends in New York City where abortion became available on request on 1 July 1970. They tend to discount some of the prophecies of adverse long-term sequelae:

| Infant mortality rate per 1000 live births | |
|---|--------------------|
| 1969 | 24.4 |
| 1970 | 21.6 |
| 1971 | 20.9 |
| 1972 | 20.1 |
| 1973 | 19.7 (provisional) |

119. A. Korda, letter, *MJA*, 27 April 1974, p. 680.

120. R. S. Ledwood, *British J of Clinical Practice* 28, 5 (1974), pp. 166-9; N. M. Clow and A. C. Crompton emphatically agree: 'The wounded uterus: pregnancy after hysterotomy', *BMJ* 1 (1973), pp. 321-3.

121. Janet R. Daling and Irvin Emanuel, 'Induced abortion and subsequent outcome of pregnancy: a matched cohort study', *Lancet*, 26 July 1975, pp. 170-2.

122. An earlier study by J. F. Donnelly et al. found that prematurity was twice as frequent in women under 20 than among those over 29 with the same birth order, and also was more frequent among poor women and short women: *AmJOG* 88 (1964), p. 918. Another study confirms this: 'Teenage women constitute a special case, in that any pregnancy, be it terminated by abortion or by a full-term birth, seems to increase the risk of prematurity in subsequent pregnancies', *International Family Planning Digest* 1, 3, p. 10.

123. Daling & Emanuel, p. 170.

124. Moore-Cavar, 1974, p. 642.

| Incomplete abortions (spontaneous and septic, admissions to municipal hospitals) | |
|--|------|
| 1969 | 6524 |
| 1970 | 5293 |
| 1971 | 3643 |
| 1972 | 3538 |
| 1973 | 3253 |

Lowered infant mortality rates may in part be accounted for by reductions in the number of babies born to very young women and older women. This has been accomplished through increased use of contraception, induced abortion and sterilisation.

192. We have found no studies which have dealt adequately with the question of sterility following induced abortion. It is the most difficult research problem to resolve as there are so many factors to be considered. Illegal abortion and subsequent salpingitis may cause sterility; intervening gynaecological disorders and birth problems may also cause sterility. Other general health problems may have some influence.

193. There is so far no available evidence that legal abortion under good conditions causes subsequent sterility. It must be kept in mind that when it does occur, it can either be a source of distress or of relief that further pregnancies are avoided.

194. We have not discussed Rhesus immunisation. Good medical practice requires that all patients with Rh-negative factor should receive immunoglobulin treatment immediately after an abortion to prevent difficulties in future pregnancies. There is no reason for it to be a problem except with illegal abortion, or less than careful medical practice.

The Wynn report

195. In 1972 Margaret and Arthur Wynn published their report *Some consequences of induced abortion to children born subsequently*.¹²⁵ They claimed to have found evidence 'that abortion frequently reduces a woman's future reproductive capability' and 'also increases the risks to subsequent children'. More specifically:

Induced abortion increases perinatal mortality, subsequent spontaneous abortions, subsequent ectopic or extra-uterine pregnancies, the proportion of premature births, and a variety of other complications affecting subsequent pregnancies.¹²⁶

196. These conclusions are not substantiated by examination of the studies referred to in the report. The text emphasises all the studies with negative findings and it does not discuss the difficulties of making such studies methodologically sound. Some studies with positive findings were not mentioned in the text (though they were included in the bibliography). Other studies were misinterpreted and the findings of one completely reversed. Also, some psychosocial interpretations of dubious nature were offered, such as the possibility that abortion prior to marriage may be 'a cause of severe marital stress subsequently, leading to marital breakdown, separation and divorce'.¹²⁷

125. M. Wynn & A. Wynn, *Some consequences of induced abortion to children born subsequently* (Foundation for Education and Research in Childbearing, London, 1972).

126. *ibid.* p. 11.

127. *ibid.* p. 15.

197. Some of the studies we have already noted were cited by the Wynns, but only the negative ones, and without qualification. In addition, the Wynns used the work of Butler and Bonham, *British perinatal mortality survey*¹²⁸, to show that even one abortion could cause 'a 50 per cent increase in perinatal mortality'.

198. That work was written in 1963 and referred in 90 per cent of the cases to spontaneous abortions, a small percentage of therapeutic abortions performed on very ill women, and illegal septic abortions.

199. Another study was misinterpreted and the findings reversed. This was Matsunaga's Japanese study of 1966.¹²⁹ The Wynns stated that Matsunaga's study showed that the infant death rate from congenital malformations had increased by 43 per cent during the 6 years following legalisation of abortion. In fact the study showed that congenital malformations had actually declined significantly despite the incomplete registrations of these infants in the post-war period. The infant death rate from this cause was 23.7 per 10 000 in 1950, and 19 per 10 000 in 1960. The author declared that the first figure was probably an underestimate.

200. The statistical significance of other studies was exaggerated and crucial factors were ignored, such as in the case of Zwahr's study.¹³⁰ This study dealt only with patients with pre-existing pathology, but the Wynns used it to indicate high morbidity in association with induced abortion.

201. The Wynn report has been criticised by Malcolm Potts and Rachael Shadbolt¹³¹, James Trussell¹³², Carol Buck and Kathleen Stavrakys¹³³, and Dennis, Diggory, and MacGillivray.¹³⁴ Anthony Ogborn¹³⁵ criticises some misuse of data in the Wynn report, but does express concern over the increased prematurity rate in Hungary and predicts similar increases for Britain. Anthony Hordern, on the other hand, holds that the vacuum aspiration method will preclude such long-term complications as cervical incompetence, prematurity etc.¹³⁶ The definitive answer to these worrying questions will, hopefully, be available in 1977.

Psychological and social sequelae of induced abortion

202. Henry P. David, director of the Transnational Family Research Institute and Associate Clinical Professor in the Department of Psychiatry, School of Medicine, University of Maryland, makes the following comment about the psychological aspects of induced abortion:

It may well be a truism that there is no psychologically painless way to cope with an unwanted pregnancy. While an abortion may elicit feelings of guilt, regret, or loss, an alternative solution, such as entering a forced marriage, bearing an out-of-wedlock child, giving a child up for adoption, or adding an unwanted child to an already strained marital situation, is also likely to be accompanied by psychological problems for the woman, the child, the family, and society.¹³⁷

128. N. R. Butler and D. G. Bonham, *British perinatal mortality survey* (Livingstone, 1963), p. 32.

129. E. Matsunaga, 'Some genetic consequences of family planning', *Journal American Medical Association* 198 (1966), p. 533.

130. Chr. Zwahr, 'Zur Problematik der legalen Schwangerschaftsunterbrechung', *Zbl. Bynak* 94, pp. 156-63.

131. M. Potts & R. Shadbolt, 'Long-term side effects of abortion', *Family Planning*, July 1973, pp. 44-7.

132. J. Trussell, 'Third thoughts on abortion', *British Journal of Hospital Medicine*, May 1973, pp. 601-4.

133. Letter, *British Medical Journal*, 4 August 1973.

134. Letter, *British Medical Journal*, 9 June 1973.

135. A. Ogborn, letter, *British Medical Journal*, 14 April 1973.

136. A. Hordern, letter, *British Medical Journal*, 12 May 1973.

137. Henry P. David (ed.), 'Abortion in psychosocial perspective' in *Abortion research: international experience* (Heath & Co., Massachusetts, 1974), p. 109.

203. In other words, we can make no sensible evaluation of the psychological sequelae of induced abortion without at the same time considering those of the inevitable alternative—childbirth, particularly after abortion has been refused.

204. Nor should we overlook the consequences of refused abortion to a child born under these circumstances. Hence this section falls into three parts:

- (a) Psychological sequelae of induced abortion
- (b) Sequelae of childbirth
- (c) Sequelae of refused abortion
 - (i) Effect on women refused
 - (ii) Effect on children born of women refused

Psychological sequelae of induced abortion

205. The assessment of psychological aspects of abortion is fraught with even more difficulties than is the assessment of physical sequelae. Whether it is based on observation or on comments elicited from the patient, analysis of mental states is a highly personal and subjective procedure (particularly when working in a contentious area), moreover workers in this field lack both a standardised terminology and firm criteria for classifying mental states.

206. Daniel Callahan, who in 1970 completed the most definitive study available of induced abortion in all its aspects, refers to 'the inadequacy of the data and a lack of anything approaching methodological refinement' in the area of the psychological.

Some of the professional psychiatric judgments may be quite sound and others quite biased; but it is just about impossible in most cases to know which is which.

He calls the psychiatric literature 'a conceptual desert'.¹³⁸

207. Adding to the difficulty is the aspect stressed by members of the Committee on the Working of the Abortion Act in England, that of distinguishing between the effects of the operation itself and the circumstances associated with unwanted pregnancy.¹³⁹ That is, what are the risks *inherently* associated with induced abortion, and what are caused by other factors such as:

- (a) Community attitudes to abortion, reactions of relatives and neighbours.
- (b) The pre-existing mental state of the patient, which may include mental illness or neurosis, and/or subconscious motivations underlying the conception.¹⁴⁰
- (c) The extent of the existence of 'drama' in association with the procedure; that is, the sordid trappings of an illegal abortion, or the stress and indignities which may attend facing hospital boards or a series of doctors.
- (d) Attitudes to the patient conveyed by personnel involved with the procedure in all its phases.
- (e) Difficulties and stresses in later life which may cause some patients to focus on an earlier abortion experience.

138. D. Callahan, *Abortion: law choice and morality* (MacMillan, New York, 1970), pp. 71–2.

139. Lane report, vol I, p. 53.

140. B. Raphael, 'Psychosocial aspects of induced abortion', *Medical Journal of Australia*, 1 July 1972, pp. 35–40, and 8 July 1972, pp. 98–101.

208. A submission to the Commission describes procedures involved in Swedish abortion requests as they were prior to 1965:

The usual procedure is as follows: A woman considering abortion goes to one of the special advisory centres on abortion where she receives a thorough gynaecological examination and, as a rule, a psychiatric evaluation as well. Her application is then forwarded to the board, accompanied by her birth certificate, a biography, usually compiled by social workers and including detailed descriptions of the applicant's personal life (family history, childhood environment, education, sexual life, finances, housing, number of children etc.)—all verified by social workers in home visits and interviews—and, finally, a medical certificate from a licensed doctor, based on his personal examination of the woman and including a description of her physical and mental condition plus a statement of his opinion as to whether the pregnancy ought to be interrupted, and why. (All of these documents are confidential.)

Usually, within a week of receiving an application, the board turns it over to its Social-Psychiatric Committee, which meets once a week . . . The Committee may ask medical specialists for an opinion on a case or they may arrange to have the applicant examined at a special institution. Applicants may not appeal against the Committee's decisions, but they may ask it to reconsider if they feel they have further evidence.

Finally, a woman may have her application reviewed by the Royal Medical Board. If permission is granted, the abortion must be performed in a public hospital by a staff surgeon.¹⁴¹

The author of the submission comments: 'This is not for an application to join the CIA or become president of the United Nations, but merely to limit the size of one's family to that with which one can cope.' These procedures should be kept in mind when looking at Swedish studies of psychological sequelae.

209. Sanford Wolf has referred to this kind of 'drama' as 'a distortion built into the doctor-patient transaction' by the patient's necessity to prove she has grounds. He adds that:

. . . the evaluation and the administrative procedures leading to abortion are often so prolonged and strained that they, in themselves, might be a proper subject for psychological research.¹⁴²

210. The legal situation may have a significant effect on the behaviour of abortion-seeking women. If mental disorder is a prerequisite for obtaining abortion, then women desperate for an abortion may assume the 'necessary' behaviour.

Many authors have noted that it is pointless to study the psychiatric 'condition' of women who must try to appear 'crazy' in order to qualify for a legal abortion; their post-abortion state, as well as their pre-abortion condition, is likely to be affected by their role-playing and self-convincing 'crazy' behaviour, or by their desire to appear still a little 'crazy' post-abortion so as not to seem to have exaggerated their pre-abortion condition, or by their desire to convince the investigator that the abortion 'cured' them.¹⁴³

It is likely that even minimally intelligent women are able to assume the kind of behaviour or role society or the medical profession deem appropriate before the granting of an abortion.

211. Other factors which may influence psychological outcomes are: age, parity, race, socio-economic status, marital status, legality of abortion, stage of gestation, whether the abortion was for psychosocial or for medical reasons and the type of operative procedure used.¹⁴⁴

141. Submission 73, Jo Wainer; see also Callahan, p. 186.

142. S. Wolf, in Sidney H. Newman et al. (eds), *Abortion obtained and denied: research approaches* (The Population Council, NY, 1971), p. 53.

143. Moore-Cavar, p. 532.

144. Wolf, p. 49.

212. It is difficult, or impossible, to evaluate the extent of these factors, their interaction, and their effects upon individual patients, hence any conclusions we may make in this area should be tentative, given present methodological shortcomings and environments potentially anxiety producing for women seeking abortions. Theoretically, there are only two 'scientific' ways one could rationally assess psychological sequelae. One is to examine carefully the same woman both after an abortion and after the unwanted birth, which is logically impossible, or to take two groups of unhappily pregnant women carefully matched for all possible relevant variables, and grant one half an abortion while refusing the other, which would be inhumane.

Survey of literature

213. The earliest literature deals with illegal abortion and relates to those women seen by psychiatrists to have serious post-abortion complications. In this period, there was no way of determining the numbers of women who had experienced abortion and who had not presented to psychiatrists. Lacking analysis in depth and controls, it would also be difficult to determine whether the abortion had been one of several factors contributing to mental disturbance, a precipitating factor or a sole cause. Most studies failed to distinguish the psychiatric sequelae of abortion from pre-existing psychiatric illness, nor did they distinguish between guilt and serious psychiatric illness. Nevertheless reports of the few cases presenting to psychiatrists have been seen for several decades as warnings to the medical profession that induced abortion is psychologically hazardous. Also, psycho-analytic theories concerning the instinctive nature of woman's desire for motherhood and the dangers of interrupting this process have reinforced this view.¹⁴⁵

214. Simon and Senturia¹⁴⁶ reviewed the literature for the period 1935-64 and reported that the findings ranged from 43 per cent of women with severe guilt after abortion and an additional 12 per cent with psychiatric illness, to 11 per cent with serious self-reproach and 1 per cent major psychiatric disability, to complete absence of either phenomenon. They declared it:

... sobering to observe the ease with which reports can be embedded in the literature, quoted and requoted many times without consideration for the data in the original paper. Deeply held personal convictions frequently seem to outweigh the importance of data, especially when conclusions are drawn.

215. Taussig's paper of 1936¹⁴⁷ appears to have been misused in this manner. He found psychoses following abortion in three cases, only one of which was from his own practice. Moreover, that patient had had severe psychiatric illness prior to the abortion. Simon and Senturia state that:

... although Taussig makes only the most cursory references to psychiatric sequelae of therapeutic abortion, he is quoted by nearly every author since 1936 as warning against serious psychiatric sequelae to abortion.¹⁴⁸

216. Ekblad's 1955 study¹⁴⁹ has been similarly used. Of 479 Swedish women followed up after abortion, 74 per cent (or 354) had no regrets or self-reproach; 14 per cent (67) experienced mild reproach, 11 per cent (53) serious regrets. In 1 per cent of

145. Fingerer's study which examined five groups of people for anxiety and depression found that post-doctoral students of psycho-analysis *predicting* post-abortion reactions scored the highest, with women who had actually experienced abortion the day before scoring the lowest on anxiety and depression: M. Fingerer, 'Psychological sequelae of abortion: anxiety and depression', *Journal of Community Psychology* 1, 2 (1973), pp. 221-5.

146. N. M. Simon and A. G. Senturia, 'Psychiatric sequelae of abortion', *Archives of General Psychiatry* 15 (1966), p. 378.

147. F. J. Taussig, *Abortion, spontaneous and induced* (C. V. Mosby Co., St Louis, 1936).

148. Simon and Senturia, p. 378.

149. M. Ekblad, *Acta Psychiatrica Scandinavica*, Suppl. 99, 1955.

the patients (5), all of whom had severe neurosis before the abortion, there was an impaired capacity for work. Those researchers unfavourably disposed towards abortion have interpreted this study as a contra-indication for it; those sympathetic see it as a justification for abortion.

217. Myre Sim, on the one hand, states that of those selected for abortion 25 per cent (120) later expressed regret, which convinced him that ‘“not wanting” the pregnancy is a temporary state of mind’.¹⁵⁰ On the other hand, Kay and Schapira believe that while 25 per cent of the women experienced self-reproach or regret:

... from the psychiatric point of view the symptoms were generally mild, that few women had consulted a doctor, and that only five were unable to work. All of the latter had difficulties not directly due to the abortion.¹⁵¹

Hence, ‘the outcome after legal abortion is good in 85 per cent’ (or 407 cases).¹⁵²

218. Ekblad’s study and the response to it illustrate the partisan way in which abortion data can be used.

219. The following are summaries of all available studies of the psychological effects of induced abortion conducted since 1950, dealing with fifty or more cases¹⁵³, and listed roughly chronologically as to when the study took place.

220. 1951 Malmfors¹⁵⁴ Stockholm 84 cases

Malmfors found ten cases of impaired mental health, all of whom had pre-abortion neuroses.

221. 1960–71 Beric et al.¹⁵⁵ Yugoslavia 62 620 cases

Beric et al. divided abortion procedures into three phases, and analysed psychological states at each phase:

The post-abortion phase was indicated as being the most disagreeable to 22 per cent of the cases, mainly by women who were ambivalent towards the termination of pregnancy and who after the operation were still ambivalent. However, they recovered from this very quickly. No cases of serious sequelae or lasting guilt feelings were noted. The most frequent reaction after termination of pregnancy was the feeling of relief . . . Compared with legal abortion, the trauma caused by an unwanted pregnancy, the birth of an unwanted child or a criminal abortion entails far greater somatic and psychic complications and leaves far more frequent and lasting sequelae, which are far more dangerous to the woman, her family and society.

222. 1963 Kummer¹⁵⁶ surveyed thirty-two Los Angeles psychiatrists and data from other countries. He found that:

Seventy-five per cent had never encountered any moderate to severe psychiatric sequelae of abortion. The remaining 25 per cent encountered such sequelae only rarely, the highest figure reported was six cases in 15 years of practice. The average length of practice in the group surveyed was slightly over 12 years.

Presumably, most of these cases would have resulted from illegal abortions. In Copenhagen, Kummer found no serious after-effects in 30 000 legal abortions surveyed. He also reviewed Scandinavian, Israeli and Japanese findings and concludes:

150. M. Sim, *British Medical Journal*, 4 March 1967, pp. 563–4.

151. D.W.K. Kay and K. Schapira, ‘Psychiatric sequelae of termination of pregnancy’, *British Medical Journal*, 4 February 1967, p. 299.

152. *ibid.*, p. 299.

153. In the interests of statistical significance.

154. Karin Malmfors, *Svensk. Lakartidn* 48, 2445 (1951).

155. Beric et al, *AmJOG*, 1973, pp. 813–21.

156. Jerome M. Kummer, *AmJPsych.* 119 (1963), pp. 980–3.

Preliminary findings reveal that psychiatric sequelae of moderate to severe intensity following abortion are very rare, markedly less than the incidence of psychiatric illness related to pregnancy and childbirth . . . Enforcement of the taboo against abortion is considered the basis for the widespread myths in this area and resistance to factual documentation.

223. 1962–68 Pare & Raven¹⁵⁷ St Batholomew's Hospital London 128 cases

All but two were:

. . . glad that they had been terminated, and the most striking general impression was the lack of serious psychological sequelae . . . the two patients who had regrets were women who were terminated largely on account of their husband's mental illness.

224. 1963–65 Peck & Marcus¹⁵⁸ Mt Sinai Hospital USA 50 cases

The psychiatric status of 92 per cent . . . was improved or unchanged . . . 98 per cent would . . . with hindsight . . . again elect abortion in preference to continuing pregnancy.

225. 1963–65 Niswander et al.¹⁵⁹ Buffalo State Univ. Hosp. NY 116 cases

Sixty-six per cent 'felt better' immediately following the abortion, 83 per cent similar in 8 months; six had doubts that abortion had been the best solution, but most of these felt it had been necessary under the circumstances.

226. 1965 Jansson Salgren's Hospital Goteborg 57 cases

The National Right to Life Association has drawn attention to Bengt Jansson's study 'Mental disorders after abortion'.¹⁶⁰ In his study he compared the mental states of women in three categories: those undergoing legal abortion; those experiencing illegal abortion; and those delivered at full term. He found that:

The frequency of insufficiencies was . . . higher after legal abortions than after others (1.92 and 0.27 respectively), and also higher than after deliveries (1.92 and 0.68 respectively). This observation is not in itself surprising since, as a rule, the motive for granting legal abortion is an increased psychic vulnerability.

227. Other studies do not support these comparisons, but in Scandinavia in this period therapeutic abortion was difficult to obtain, restricted to extreme cases, and accompanied by much 'drama', as described above. The mentally healthy would turn to illegal abortion, but even so the figures on this category would always be extremely unreliable. The figures for post-partum difficulties is also at variance with others. Jansson also reviews several studies of post-abortion mental states including Ekblad's (also Swedish), and concludes that of those experiencing difficulty after abortion:

The mental condition and social situation of these women . . . was such that they would probably have experienced symptoms just as serious if the pregnancy had not been interrupted by abortion.¹⁶¹ He found Hook's study confirmed this view and indicated 'a worse state of health in these women than in the women granted legal abortions'.¹⁶²

Jansson's overall conclusion is that:

. . . women who are psychically vulnerable risk a deterioration in their condition through an unwelcome pregnancy and the extra load this involves, whatever course is adopted.¹⁶³

157. C.M.B. Pare and Hermione Raven, 'Follow-up of patients referred for termination of pregnancy', *Lancet* 1, 7648 (1970), pp. 635–8.

158. A. Peck and H. Marcus, *Journal Nerv. Ment. Dis.* 143 (1966), p. 417.

159. Kenneth Niswander and Robert Patterson, 'Psychologic reaction to therapeutic abortion', *Obstetrics and Gynaecology* 29 (1967), pp. 702–6.

160. B. Jansson, 'Mental disorders after abortion', *Acta Psychiatrica Scandinavica* 41, 87 (1965), p. 87.

161. *ibid.* p. 87.

162. *ibid.* p. 88.

163. *ibid.* p. 110.

228. 1966 Clark et al.¹⁶⁴ University College Hospital London 120 cases
Seventy improved permanently and twenty-three benefited temporarily. Only one was known to be emotionally worse, which is some evidence to refute the fear that psychiatric damage is common. In our view it can nearly always be avoided by selection and psychiatric support during the woman's stay in hospital and after. The attitude of those around her is extremely important—and, if adverse, can outweigh the psychiatric help provided.
229. 1968 Levene & Rigney¹⁶⁵ San Francisco 56 cases
Properly done induced abortion does not in itself result in significantly noxious emotional sequelae.
230. 1969 Lader¹⁶⁶ USA 282 cases
55 per cent 'glad without reservation'
33 per cent 'not happy but knew that the abortion was necessary'
8 per cent 'satisfied but doubtful'
0.3 per cent 'regretted' the abortion
Lader concludes that 82 per cent had experienced no damage; 11 per cent had been affected emotionally, but not seriously. None needed further treatment.
231. 1968–70 Barnes et al.¹⁶⁷ Mass. General Hospital Boston 114 cases
From follow-up questionnaires and interviews, we conclude that the patients' experience with therapeutic abortion produced little handicap in most and constructive gains in many . . . it is becoming apparent that the extremely cautious attitude of many American physicians is difficult to justify on medical or psychological grounds and may, in fact, account in part for the difficulty the United States has in lowering its maternal mortality figures to levels similar to those in other industrialised societies.
232. 1970 Marder¹⁶⁸ 147 cases
Marder noted a relationship between negative and hostile attitudes on the part of hospital personnel, inadequate counselling and consideration for the patient's emotional state and the incidence of post-abortion guilt, remorse and depression.
233. 1968–70 Todd¹⁶⁹ Leverndale Hospital and the Victoria Infirmary Glasgow
69 cases followed up 1 to 3 years after abortion
Sixty-three or 91.3 per cent showed no adverse sequelae. Six showed some disturbance which the author attributes either to pre-existing neurosis or intervening life stresses.
A poor outcome may . . . be expected when there is severe and continuing social stress. In all these cases, however, it could be argued that the outcome might have been even worse if the pregnancy had continued.

164. M. Clark, I. Forstner, D. A. Pond and R. F. Tredgold, 'Sequels of unwanted pregnancy: a follow-up of patients referred for psychiatric opinion', *Lancet*, 31 August 1968, pp. 501–3.

165. H. Levene and F. Rigney, *J. Nerv. Ment. Dis.* 151, 51 (1970).

166. L. Lader in A. Hordern (ed.), *Legal abortion: the English experience*, p. 231, and *Look*, 21 January 1969.

167. Ann B. Barnes, Elisabeth Cohen, John D. Stoeckle and Michael T. McGuire, 'Therapeutic abortion: medical and social sequels', *Annals of Internal Medicine* 75, 6 (1971), pp. 881–6.

168. L. Marder, 'Psychiatric experience with a liberalised abortion law', *American Journal of Psychiatry* 126 (1970), pp. 1230–6.

169. N. A. Todd, 'Psychiatric experience of the Abortion Act (1967)', *British Journal of Psychiatry* 119 (1971), pp. 489–95.

N. A. Todd, 'Follow-up of patients recommended for therapeutic abortion', *British Journal of Psychiatry* 120 (1972), pp. 645–6.

234. 1969–70 Smith¹⁷⁰ Pregnancy Consultation Service St Louis Missouri 80 cases

Eighty cases were followed up 1 to 2 years after abortion. They had also been interviewed in depth before and after the abortion. Using the Feigner diagnostic criteria¹⁷¹, 17 per cent were found to have pre-existing mental illness: symptoms relating only to the pregnancy were excluded.

235. The psychological reaction to abortion immediately afterwards and at time of follow-up are summarised in Table IV. P. 22.

Table IV. P. 22

| Reaction | Immediately afterwards | At follow-up |
|---|------------------------|--------------|
| | % | % |
| None | 78 | 90 |
| Mild discomfort (noticed by subject but not of real concern to her) | 9 | 6 |
| Moderate discomfort (caused concern to subject and/or others) | 7 | 2 |
| Severe discomfort (prolonged, and impaired functioning) | 6 | 2 |

Source: Smith, *Am J Orthopsychiat* 43, 4 (1973), pp. 574–85.

Many of the women reporting negative psychological reactions indicated feelings of relief and satisfaction; few experienced depression, remorse or guilt. All of the women who experienced moderate to severe discomfort afterwards were unmarried, and most were teenagers. Those who regretted their decision felt they had been pressured by others into the abortion. There was no evidence that previous psychiatric history influenced the patient's later adjustment.

236. Smith found that many of the women regarded the experience of abortion as a 'growth-producing or maturing process'. Some found the experience had brought them closer to their parents; others reported that the abortion had enabled them to remain in school, to continue working, or to avoid a potentially unhappy marriage.

Most of the women felt the abortion had a positive effect on their lives, and only 3 per cent strongly regretted their decision.

237. 1970 Osofsky et al.¹⁷² Upstate Medical Centre Syracuse NY 250 cases

As a result of post-abortion follow-up interviews with these cases the following psychological evaluations were made:

| Category | | Category | |
|--------------------|------|-------------------------|------|
| Predominant mood | % | Feelings about abortion | % |
| Very unhappy | 4.2 | Negative—much guilt | 8.2 |
| Moderately unhappy | 10.5 | Moderate guilt | 15.6 |
| Neutral | 20.7 | Neutral | 13.4 |
| Moderately happy | 20.0 | Moderate relief | 14.8 |
| Very happy | 44.6 | Positive—much relief | 48.0 |

170. E. M. Smith, 'A follow-up study of women who request abortion', *Am J Orthopsychiat* 43 4 (1973), pp. 574–85.

171. J. Feigner et al., 'Diagnostic criteria for use in psychiatric research', *Arch. Gen. Psychiat.* 26 (1972), pp. 57–63.

172. Joy D. Osofsky, Howard J. Osofsky, Renga Rajan and Michael R. Fox, 'Psychologic effects of legal abortion', *Clinical Obstetrics & Gynaecology* 14, 1 (1971), pp. 215–34.

| Category | % | Category | % |
|-----------------------|------|------------------------|------|
| Physical emotionality | | Attitudes towards self | |
| Much crying | 8.2 | Negative—angry | 1.5 |
| Moderate crying | 7.6 | Moderate anger | 7.2 |
| Neutral | 15.8 | Neutral | 12.6 |
| Moderate smiling | 19.0 | Moderate happiness | 17.6 |
| Much smiling | 49.4 | Positive—happy | 61.1 |

Among the authors' conclusions are:

Wherever objective studies have been performed, there has been a low incidence of psychological sequelae . . . in no case has the incidence of problems been high—and in most cases one may question whether the abortion or pre-existent difficulties provoked the sequelae. The predominant reaction would appear to be relief.¹⁷³

In the United States, in spite of the problems, both illegal and therapeutic abortion have apparently been compounded by few psychologic sequelae. Psychiatrists see almost none of the large numbers of women who have obtained an illegal procedure; when interviewed, they report few problems. Even among individuals obtaining a therapeutic procedure, who have had to prove themselves ill to the medical community, significant psychologic sequelae are rare. In this light, it is of interest to note that women too healthily to receive an abortion in Sweden have a higher incidence of subsequent emotional incapacitation than have those who were disturbed enough to obtain an abortion.¹⁷⁴

238. 1971 Pasnau¹⁷⁵ 150 cases

. . . one documented case of a serious emotional reaction after the procedure.

Pasnau concludes on the basis of his own study and an examination of the findings of others:

- (a) There should be no routine psychiatric consultation, as requesting abortion is not, in his opinion, a *prima facie* sign of mental illness. Routine referral may cause feelings of guilt or 'make the patient feel that she is doing something "wrong" or "crazy" '.
- (b) Psychiatric evaluation should be requested if the patient exhibits signs of a major psychiatric illness, or has a history of previous post-partum psychosis; if the patient is ambivalent over her decision; if the patient appears to be 'passively compliant with the wishes of parents or spouse, but does not herself wish to have an abortion'.
- (c) All patients should be seen in routine follow-up visits. Pasnau believes this could prevent any serious trouble and would give us more necessary information about the post-abortion period.

239. 1971 Meikle et al.¹⁷⁶ University of Calgary and Foothills Hospital Calgary Alberta Canada 75 cases

Personality tests administered to seventy-five women applying for therapeutic abortion were compared to those of thirty-three women in the same period of pregnancy but not requesting an abortion.

173. *ibid.*, p. 229.

174. *ibid.*, p. 230.

175. Robert O. Pasnau, *Ob & Gyn* 40, 2 (1972), pp. 255–6.

176. Stewart Meikle, Harry Brody, Richard Gerritse, George Maslany, 'Therapeutic abortion: a prospective study. Part II', *American Journal of Obstetric Gynaecology*, 1 February 1973, pp. 339–46.

The abortion applicants reported more severe and more frequent psychosomatic difficulties both prior to and during the current pregnancy . . . [this] leads to a conclusion that women with a history of relatively frequent psychosomatic problems are more likely to seek therapeutic abortion. Since they have apparently in the past reacted to life stresses with a variety of somatic symptoms, they are likely to exaggerate this pattern with an unwanted pregnancy and to seek termination.

The difficulty with this study is that it was not controlled for other variables which may be considerable between those requesting termination and those wishing to continue pregnancy. This study could merely be indicating that women who seek abortions are experiencing more difficulties in life than other pregnant women. Moreover, the authors note:

. . . it was found over a 1-year follow-up of women who had undergone an abortion that the initially high psychopathology gradually disappeared over the 1-year period.¹⁷⁷

240. 1970-71 Weston¹⁷⁸ South Australia 140 cases

These cases were followed up at 1 month, and 117 at 6 months.

In general they did well. Little psychiatric disturbance appeared and only some of this could be attributed to the abortion. Fifty-six per cent of the women believed themselves 'better' 6 months after their abortion than they were 6 months before it.

Two had indicated that they felt the abortion had not been in their best interest. Of Weston's sample, two had been seriously disturbed before the pregnancy, three had a history of serious mental illness such as puerperal depression or schizophrenia. Some had suffered nervous breakdown, or a nervous condition. A total of eight were considered in need of psychiatric treatment for conditions existing before the pregnancy. Six of these entered therapy after abortion. Weston believes that where abortion is not genuinely therapeutic, the woman had not really wanted it, or had been ambivalent.

241. 1970-71 Ewing et al.¹⁷⁹ North Carolina Memorial Hospital 126 cases

A follow-up study of 126 women who received abortions on psychiatric grounds revealed that the fifty-two women with a history of prior psychiatric illness did not experience significantly more post-abortion emotional reactions than the others. Ninety-six per cent of the psychiatric group and 92 per cent of the others reported that their emotional health was better or normal afterwards.

242. 1970-71 Miller¹⁸⁰ South Australia 349 cases

The small incidence of psychiatric impairment, between 1 per cent and 2 per cent, corresponded with that reported in the literature . . . These patients had evidence of long-standing pre-existent psychiatric illness.

However, there is some doubt as to the value of this conclusion in that, according to Miller, despite the high physical complication rate of 49 per cent, 'half of the patients for whom outpatient follow-up had been arranged defaulted [sic]'. He also expressed doubt as to 'the degree of compliance' obtained from patients requested to see their own doctor¹⁸¹, indicating no attempt or means to follow up these patients. One wonders, then, how the 'between 1 per cent and 2 per cent' figures were arrived at. In view of the fact that 23 per cent were sterilised, it is surprisingly low.

177. *ibid.*, p. 346.

178. Frank Weston, 'Psychiatric sequelae to legal abortion in South Australia', *Medical Journal of Australia* 1, 7 (1973), pp. 350-4.

179. John A. Ewing, Beatrice A. Rouse, 'Therapeutic abortion and a prior psychiatric history', *American Journal of Psychiatry* 13, 1 (1973), pp. 37-40.

180. John B. Miller, *MJA*, 28 April 1973.

181. *ibid.*, p. 829.

243. 1971-72 Greer et al.¹⁸² King's College Hospital London 360 cases

This study differs from most in that the psychological assessments were made after abortion had been granted, but before the procedure had been carried out. This would tend to eliminate any tendency to exaggeration of neurotic symptoms by patients as a means of gaining permission for termination of their pregnancy. Careful follow-ups were carried out at 3 months and approximately 18 months. The results were assessed in terms of psychiatric symptoms, guilt feelings and adjustment in marital and other interpersonal relationships, sexual responsiveness and work record. It was found that significant improvement had occurred at follow-up in the areas of psychiatric symptoms, guilt feelings and interpersonal and sexual adjustment; there was no significant change in marital adjustment. Adverse psychiatric and social sequelae were rare.

244. 1970-72 Athanasiou et al.¹⁸³ 114 cases

In a unique study, three matched groups were compared, one group planning term deliveries, one obtaining early abortion, and another obtaining second trimester saline abortions. Detailed questionnaires and in-depth interviews during pregnancy and 1 year after the event were used. The only significant difference among the three groups was in the area of paranoia where it was found that those patients going to term had higher scores than either the first or the second trimester abortion patients. The authors therefore questioned the supposition that abortion is a psychologically damaging procedure.

245. 1970-71 JPSA¹⁸⁴ USA 73 000 cases

The JPSA found psychiatric complications of 0.2 per thousand abortions, with 0.4 per thousand for local women with follow-up evaluation. The study group found that although:

... abortion may elicit feelings of guilt, regret or loss in some women, these reactions tend to be temporary and appear to be outweighed by positive life changes and feelings of relief. Moreover ... although abortion may indeed be followed by some minor negative feelings, major psychiatric trauma is essentially non-existent.¹⁸⁵

The study group also noted that comparisons between abortion and term delivery are difficult to assess, but commented: 'There is no evidence that abortion is significantly more hazardous psychologically than is term delivery.' The group was particularly concerned about 'The linkage between the legal and cultural status of abortion and its psychological effects' as posing:

... a complex problem for researchers hoping to isolate the consequences of abortion. If adverse reactions are clearly present, it is difficult to determine whether they arise more from the abortion itself or from other factors, such as social embarrassment, that relate more to general cultural values or legal norms.

246. In this respect, Osofsky et al.¹⁸⁶ have commented on the 'paucity of data' available from countries where abortion has been readily available for some years, and speculate that the general acceptance of the procedure may preclude adverse psychological effects and would account for the lack of studies. These countries study other aspects of abortion in some depth.

182. H. S. Greer, Shirley Lal, S. C. Lewis, E. M. Belsey and R. W. Beard, 'Psychosocial consequences of therapeutic abortion', *British Journal of Psychiatry* 128, (1976), pp. 74-9.

183. Robert Athanasiou et al., 'Psychiatric sequelae to term birth and induced early and late abortion: a longitudinal study', *Family Planning Perspectives* 5 (1973), pp. 227-31.

184. JPSA, p. 90.

185. Cited by Richard Lincoln in *Family Planning Perspectives* 7, 4 (1975), p. 187.

186. Osofsky et al., p. 222.

247. Lask¹⁸⁷ Central London 50 cases

In a manner similar to Greer et al.'s study above, assessment was made before the procedure when permission had been granted, and 6 months later.

The outcome . . . was favourable for 68 per cent and unfavourable for 32 per cent. Eighty-four per cent had no regrets . . . the psychiatric status was improved or unchanged in 89 per cent of the cases. The adverse sequelae reported included feelings of loss, guilt and self-reproach, varying from mild to severe . . . In only four cases could the adverse results be related directly to the termination, rather than to the patient's environment since the operation. Even in these cases there is no evidence that the patient would have done better if the pregnancy had been allowed to continue. Many patients clearly benefited from the termination.

Lask is convinced, moreover, that:

Where there is a risk of adverse sequelae to termination, there will be an equal risk of adverse sequelae to continued pregnancy; in particular, when a pregnant woman requests termination because of environmental stress factors these factors will still be present should termination be refused. The adverse sequelae of refused termination will affect not only the woman and any family but also the unborn child.

248. 1972-73 Greenglass¹⁸⁸ 188 cases

Greenglass matched 188 women who had had legal abortions with three control groups and assessed their post-abortion reactions by means of a personality inventory designed to measure neurotic disturbance. She found no significant psychological disturbance up to 9 months after the procedure. Those with the least favourable outcome were women whose husbands were in lower status occupations wherein attitudes towards abortion are less accepting. Greenglass also stresses the importance of the attitudes of medical personnel in influencing psychological reactions to abortion, and proposes that efforts should be made to prevent contact between women having abortions and staff who cannot conceal their disapproval or rejection of these patients.

249. 1972-74 Erlanger¹⁸⁹ South Australian hospitals 207 cases

Helga Erlanger, social worker, interviewed 207 abortion patients on behalf of the Committee Appointed to Examine and Report on Abortions in South Australia. Her report 'Social issues and social aspects related to requests for abortion' included an assessment of post-abortion mental states:

In the majority of cases the reaction to abortion was one of relief . . . Several women were depressed but this was more a result of their general situation than about the abortion. This depression was not evident in the 'follow-up'.

In three instances women were still ambivalent about the abortion at 'follow-up'.

250. 1973 Adler¹⁹⁰ Boston 70 cases

Adler followed up these patients at 2 to 3 months after the procedure. They had also been interviewed before the abortion. This study is more subtle than most in that the researcher investigated the possibility that conflicting emotion, i.e. both guilt and relief, could be experienced by the same patient. She also attempted to isolate responses engendered by norm violation—or negative community attitudes to abortion—from personal responses—the meaning the particular pregnancy and abortion

187. Bryan Lask, 'Short-term psychiatric sequelae to therapeutic termination of pregnancy', *British Journal of Psychiatry* 126 (1975), pp. 173-7.

188. Esther R. Greenglass, 'Therapeutic abortion and its psychological implications', *Canadian Medical Association Journal* 113 (1975), pp. 754-7.

189. Exhibit 92 (a).

190. Nancy E. Adler, 'Emotional responses of women following therapeutic abortion', *American Journal of Psychiatry* 45, 3 (1975), pp. 446-54.

had for an individual woman. The former could cause feelings of shame or guilt; the latter regret, anxiety, depression etc. Age and marital status were found to be relevant in influencing the outcome; the intensity of emotions either way was greater in the young and unmarried than in older married women. The author concludes:

Following therapeutic abortion women may experience a variety of emotions, both positive and negative . . . Women in environments in which abortion is viewed as deviant or unacceptable are more likely to feel that their action has violated a norm and to feel guilt, shame and fear of disapproval . . . It is possible . . . that a woman may be certain that she does not want to continue her pregnancy and will have few doubts or regrets afterwards but may still feel guilt, shame and fear of disapproval if people who are near to her feel that the abortion was wrong. On the other hand, a woman whose social environment is favourable to abortion will not be likely to experience those emotions but may experience a sense of loss and the associated emotions if she did in part want to be pregnant or to have a child . . . the predominant emotional responses to abortion are happiness and relief but these emotions may often be combined with mild to moderate feelings of guilt, regret, depression etc.¹⁹¹

251. 1973-74 Fertility Control Clinic¹⁹² Melbourne Victoria 821 cases

The clinic followed up these patients with questions at the time of post-abortion check-up. These were the results:

| Attitude to the decision | |
|--------------------------|------|
| | % |
| Right | 96.8 |
| Unsure | 2.8 |
| Wrong | 0.4 |

A second series of 252 cases used a different kind of criterion:

| Reaction | |
|------------------|------|
| | % |
| None | 64.3 |
| Relief | 21.8 |
| Guilt-depression | 13.9 |

The author adds:

Of those who stated that they had felt guilty, a sense of loss or depression, most specified that this was a transitory feeling and that it did not alter their perception of the decision as correct: only three women reported that their feelings of guilt or depression were severe.

252. Looking at the studies chronologically, there appears to be a decrease in adverse sequelae as abortion has become legally available and more acceptable to the community.

253. There are indications that those working in the field of mental health have been re-evaluating their stance on abortion. In 1967 only 24 per cent of the American Psychiatric Association favoured abortion on request; by 1969, 72 per cent favoured it. In 1970 the American Psycho-analytic Association released the following position statement on abortion:

Though there are always emotional aspects of each such procedure, there is no evidence that these are necessarily negative or enduring.¹⁹³

191. *ibid.*, p. 453.

192. Submission 73, Jo Wainer.

193. In Pasnau, p. 254.

In fact, abortion is now considered by some an element of preventive psychiatry.¹⁹⁴ Sanford Wolf believes that 'As the various sequelae to abortion are explored, it is being repeatedly noted that they are far less traumatic than once believed'.¹⁹⁵

254. Zigmund Lebensohn¹⁹⁶, Chief of the Dept of Psychiatry at a large Washington DC hospital, comments that psychiatric attitudes to abortion have changed with recent experience which shows no psychiatric sequelae for well-motivated women with no psychiatric disorder.

Abortion performed after amniocentesis

255. There is one study which surveys the psychological sequelae of both parents after abortion had been performed for genetic foetal defects diagnosed after amniocentesis.

256. 1974 Blumberg et al.¹⁹⁷ University of California School of Medicine 13 couples
The incidence of depression following selective abortion may be as high as 92 per cent among the women and as high as 82 per cent among the men studied, and was greater than that usually associated with elective abortion for psychosocial indications or with delivery of a stillborn . . . Despite the emotional trauma of the procedure, most of the families studied would repeat their course of action and consider selective abortion preferable to the alternative birth of a defective child.

The study is unfortunately very small, but is significant. These couples presumably wanted more children very much, hence the findings would imply that whether or not a child is wanted is a major component in depression following induced abortion and childbirth.

Abortion performed in association with sterilisation

257. Sterilisation in association with abortion is generally more common in the early stages of legalisation than later. Eastern European countries with long experience with legal abortion seldom perform these procedures concurrently and consequently find lower mortality and morbidity rates.

258. There may also be sound psychological reasons for separating the two procedures. Few studies are to be found, but the following may shed some light:

| | | |
|------|----------------------|----------|
| 1968 | McCoy ¹⁹⁸ | 62 cases |
|------|----------------------|----------|

Twenty-seven per cent of the patients expressed varying degrees of long-term regrets and 10 per cent had bitter regrets. These cases were all sterilised in combination with abortion.

Psychological sequelae of childbirth

259. The main difficulty in assessing sequelae of abortion is that we cannot know the possible adverse psychological effects, their extent and severity, had the unwanted pregnancies gone to term. A look at the literature on post-partum mental states may offer a useful perspective. Moreover, studies to do with birth, lacking the element of controversy, appear to be more reliable and consistent than studies to do with abortion.

194. H. Whittington, 'Evaluation of therapeutic abortion as an element of preventive psychiatry', *AmJ of Psych.* 26 (1970), pp. 1224-9.

195. Wolf, p. 55.

196. Z. Lebensohn, 'Legal abortion as a positive mental health measure in family planning', *Comprehensive Psychiatry* 14, 2 (1973), pp. 93-8.

197. Bruce D. Blumberg, Mitchell S. Golbus, Mark H. Hanson, 'The psychological sequelae of abortion performed for a genetic indication', *AmJOG* 122, 7 (1975), pp. 799-808.

198. D. R. McCoy, 'The emotional reaction of women to therapeutic abortion and sterilisation', *Journal of Obstetric Gynaecology British Commonwealth* 75 (1968), pp. 1054-7.

260. Post-partum mental problems can be either very serious, in the form of psychoses, or mild, in the form of 'blues' or transient depression. The depression may, however, endure for some time after the birth, although not be serious enough to require hospitalisation.

261. Psychiatrists working in the field of psycho-obstetrics agree that post-partum psychoses generally occur in one out of 500 births.¹⁹⁹ Kaij and Nilsson found that 4 or 5 per cent of all female admissions to mental hospitals are due to such illness.²⁰⁰ They also note that in 40 to 50 per cent of the post-partum psychoses the illness is related to the pregnancy only, as far as can be determined.²⁰¹ Pitt also believes that this kind of psychosis can be related only to pregnancy, but places the incidence at approximately 11 per cent.²⁰²

262. The less serious post-partum neuroses are far more significant statistically. Kaij and Nilsson note that they are extremely common: 'As many as one woman in four experiences more or less incapacitating neurotic and/or depressive symptoms during the post-partum year.'²⁰³ They also find that 70 to 80 per cent of their post-partum patients manifest 'blues' symptoms²⁰⁴

263. Pitt estimates that the 'blues' occur in up to 80 per cent of deliveries.²⁰⁵ A National Health Service study of 305 maternity patients in a London hospital found that 50 per cent experienced the 'blues' soon after birth, while 10.8 per cent were found to be suffering from puerperal depression 9 months after the birth.²⁰⁶

Many felt quite changed from their usual selves, and most had never been depressed like this before . . . unusual irritability was common, sometimes adding to feelings of guilt. A few patients complained of impaired concentration and memory. Undue fatigue and ready exhaustion were frequent, so that mothers could barely deal with their babies, let alone look after the rest of the family and cope with housework and shopping.²⁰⁷

Other studies (Kessel, 1969; Ryle, 1961)²⁰⁸ give incidences of 9 and 10 per cent respectively for puerperal depression.

264. The high incidence of mental distress involved in childbirth is baffling if we regard all pregnancy as a natural and happy event. It is not if we consider the possibility that pregnancy, particularly unwanted pregnancy, may be more in the nature of a life crisis for a percentage of women.

199. W. G. Paterson, J. D. O. Loudon, J. G. Robertson, 'Disorders of the puerperium', in R. Passmore and J. S. Robson (eds), *A Companion to Medical Studies* 3, part 2, section 43.27 (Blackwell Scientific Publications, 1974).

Bruce Pitt, '“Atypical” depression following childbirth', *Brit. J. of Psych.* 114 (1968), p. 1325.

Jerome M. Kummer, 'A psychiatrist's view' in Robert Hall (ed.), *Abortion in a changing world* (Columbia University Press, NY, 1970), p. 99.

Lennart Kaij and Ake Nilsson, 'Emotional and psychotic illness following childbirth' in John G. Howells (ed.), *Modern perspectives in psycho-obstetrics* (Churchill Livingstone, Edinburgh, 1972), p. 364.

200. Kaij & Nilsson, p. 364.

201. *ibid.*, p. 366.

202. Pitt, p. 1332.

203. Kaij & Nilsson, p. 364.

204. *ibid.*, p. 371.

205. Pitt, p. 1325.

206. *ibid.*, p. 1327.

207. *ibid.*, p. 1327.

208. W.I.N. Kessel, 'Psychiatric morbidity in a London general practice', *British Journal of Preventive Medicine* 14, 16 (1969); A. Ryle, 'The psychological disturbances associated with 345 pregnancies in 137 women', *Journal of Mental Science* 107, 279 (1961).

265. In 1970 Nilsson and Almgren²⁰⁹ surveyed the literature on attitudes towards pregnancy, and also conducted a prospective study of 165 pregnant women. They found that:

Clearly, the circumstances accompanying the initiation of a pregnancy, especially the degree of planning and the extent to which it is or is not desirable, are of great importance for the woman's further adaptation to childbirth, from both a psychiatric and a psychological point of view.

By 1972 Kaij and Nilsson went further and expressed the belief that 'the desirability of the pregnancy' is 'a central issue' in post-partum mental distress. 'An unintentional pregnancy may imply a severe psychological trauma to some women.'²¹⁰ They discount hormonal factors as a possible cause: 'Intensive search for an endocrinological disturbance specific for psychotic parturient women has failed to prove this.'²¹¹ It may, however, be a factor in the transitory 'blues' and would therefore also be a factor in post-abortion psychological states. Kaij and Nilsson arrived at the 'desirability' hypothesis after noting that at least 10 per cent of their disturbed post-partum patients experienced thoughts of infanticide and reported 'fear of hurting the child'.²¹² They are now in the process of carrying out a prospective study using the conscious attitude towards the pregnancy, whether wanted or unwanted, at first examination, as an indication of future difficulty. What is emerging from this study is that 'a negative and, still more, an ambivalent attitude implies a high risk of neurotic symptoms post-partum'.²¹³

266. Paterson et al. have also noted that with post-partum psychotic patients:

Admission to hospital is usually required because of the severity of the symptoms which often include delusions concerning the child and there is always a risk of infanticide.

Other studies also point in this direction. Brew and Seidenberg noted that in 103 cases of psychotic reactions associated with pregnancy 'rejection of the newborn was a universal finding . . . neglect of the infant, and in some cases actual attempts at infanticide'.²¹⁴

267. Others who have found a relationship between conscious or unconscious rejection of a pregnancy and subsequent mental illnesses are Boesky et al. (1960), Kroger and Freed (1951), W. Menninger (1943) and Smalldon (1940).²¹⁵

268. In contrast to all the above studies is Myre Sim's (1963)²¹⁶, who believes that his 213 cases of post-puerperal psychosis were in no way related to the attitude to the pregnancy, and that these mental disturbances, being unpredictable, cannot serve as grounds for abortion.

209. Ake Nilsson and Per-Erik Almgren, 'Peri-natal emotional adjustment: a prospective investigation of 165 women', *Acta Psychiatrica Scandinavica*, Supplementum 220, (1970), pp. 123-37

210. Kaij & Nilsson, p. 375.

211. *ibid.*, p. 367.

212. *ibid.*, p. 372.

213. *ibid.*, p. 382.

214. Mary F. Brew and Robert Seidenberg, 'Psychotic reactions associated with pregnancy and childbirth', *Journal of Nervous and Mental Diseases* 111 (1950).

215. D. Boesky, T. N. Cross, G. W. Morley, 'Post-partum psychoses', *AmJOG* 80 (1960), pp. 1209-17.

W. S. Kroger, S. C. Freed, *Psychosomatic gynaecology* (Saunders, Philadelphia, 1951).

W. C. Menninger, 'The emotional factors in pregnancy', *Bulletin Menninger Clinic* 7 (1943), pp. 17 ff.

J. L. Smalldon, 'A survey of mental illness associated with pregnancy and childbirth', *American Journal of Psychiatry* 97 (1940), pp. 80-1.

216. Myre Sim, 'Abortion and the psychiatrist', *BMJ*, 20 July 1963, pp. 145-8.

269. There may be a more direct and earlier effect upon the children of disturbed mothers. A 1961 study of forty-eight pregnant women showed that women who were later to experience complications during delivery or to give birth to children with mental or physical abnormalities had displayed high scores on anxiety tests during their pregnancies.²¹⁷

270. A recent Australian study of first births reveals that:

Women who subsequently experience complications in childbirth perceive their pregnancies as having more of the attributes of a crisis than other women. They are not happy about the pregnancy, fear its outcome for the child.²¹⁸

271. A New York study found that of forty women who died in childbirth, one-half of them had stated that they had not wanted to become pregnant.²¹⁹

272. Other studies which find a negative effect on the foetus from stress during pregnancy are Stott's, Turner's and Strean's.²²⁰

273. It has been further conjectured that premature births, congenital malformations, emotional disturbances, behavioural disorders, delinquency, schizophrenia, epilepsy and mental subnormality may all be related to the emotional attitude of the mother toward the foetus or to the circumstances surrounding the pregnancy.²²¹

274. Mildred Beck is another who has commented on the psychosomatic aspects of pregnancy. She sees a:

. . . continuum of reproductive causality . . . the need for extensive studies of the factors causing or associated with complications of pregnancy and labour, since these not only influence maternal health and infant loss but apparently have an influence on the surviving infant . . . and to what extent in utero damage may be the result of poor or absent pre-natal care or the determined effort of the woman to dislodge the conceptus.

275. Beck is particularly concerned about:

. . . the very young female who, by virtue of youth alone, is already at great risk for complications of pregnancy and premature delivery. If one adds to this poverty, membership in minority groups and out-of-wedlock pregnancies, one finds other critical dimensions that must be taken into account by those concerned for the welfare of the mother and her infant. It may, therefore, be very productive to study the rates of pregnancy, in and out of wedlock, among the youngest age group and the rates of pregnancy complications and premature births as these may be related to psycho-medical morbidity in the mother and infant.²²²

217. Anthony Davids, Spencer De Vault and Max Talmadge, 'Anxiety, pregnancy, and childbirth abnormalities', *Journal of Consulting Psychology* 25 (1961), pp. 74-7.

218. I. Pilowsky, Department of Psychiatry, Uni. of Sydney, 'Psychological aspects of complications of childbirth: a prospective study of primiparae and their husbands', *Psychosomatic medicine in obstetrics and gynaecology*, 3rd International Congress, London, 1971 (Karger, Basel, 1972), pp. 161-5.

219. D. Llewellyn-Jones, *People populating* (Faber, London, 1975), p. 308.

220. D. H. Stott, 'Physical and mental handicaps following a disturbed pregnancy', *Lancet* 1 (1957), pp. 1006-12.

D. H. Stott, 'Mongolism related to emotional shock in early pregnancy', *Vita Humana* 4 (1961), pp. 57-76.

E. K. Turner, 'The syndrome in the infant resulting from maternal emotional tension during pregnancy', *Medical Journal of Australia* 1 (1956), pp. 221-2.

L. P. Strean, *The birth of normal babies* (Twayne, NY, 1958).

221. Joseph C. Rheingold, *The fear of being a woman* (Grune & Stratton, NY, 1965), p. 635.

222. Mildred B. Beck, 'Abortion: the mental health consequences of unwantedness', *Seminars in Psychiatry* 2, 3 (1970), p. 269.

276. Beck also postulates a link between unwanted pregnancy and severe post-partum depression.²²³ Kaij and Nilsson have in fact noted that nearly 80 per cent of their post-partum patients 'with psychoses complicating gross somatic illness' were unmarried primiparae.²²⁴

277. While there is no emphatic proof that adverse psychological or physiological sequelae to mother and infant will inevitably follow an undesired birth, the above studies indicate that negative attitudes or circumstances may increase the likelihood of such sequelae.

Refused abortion

278. Another related aspect is the likely outcome when a request for abortion is refused. The following are possible outcomes:

- (a) Acceptance of the decision, continuance to term and acceptance of the child.
- (b) Continuance to term with varying degrees of acceptance or rejection of the child.
- (c) Continuing search for legal abortion in another area or country.
- (d) Resort to illegal abortion with an increased likelihood of physical damage, short or long term.
- (e) Some unsuccessful attempts at self-induced abortion which may produce either direct physical damage to the mother and/or foetus, or possibly a damaged mother-child relationship in the future.
- (f) Adoption or fostering of the child.
- (g) Forced marriage.

Effect on women refused

279. Several studies have attempted to follow up women after abortion has been refused.

280. Of 155 women refused at the London Chelsea Hospital for Women 2 years after the Abortion Act came into effect, information was available on 105. Of these patients, fifty-three women continued with the pregnancy, and the remainder, approximately half, did not go to term. Among the patients' doctors who had referred the women to the Chelsea Hospital, only one agreed with the hospital's decision; the others said that the refusal had been unfair, leaving their patients embittered and upset.

281. Of the fifty-three who continued with the pregnancy, fifteen children were adopted out, thirty were kept by their mothers, two were kept by the family of the mother, one child was stillborn, and no information could be obtained about five. One refused patient who had been exposed to rubella delivered a child with deafness, cataracts and congenital heart disease.

282. Of those who arranged their own abortions, four had significant complications; one nearly died of haemorrhage and severe infection; two had severe pelvic infection; one had prolonged vaginal bleeding.²²⁵

283. In the 1961-63 Prague study²²⁶, of 555 women refused abortion after twice requesting it, 316 or 57 per cent had carried their pregnancies to term; fifty-four were not able to be followed up (six of these found not to be pregnant); 185 or one-third found other solutions.

223. *ibid.*, p. 270.

224. Kaij & Nilsson, p. 367.

225. J. M. Beazley & A. D. Haeri, 'Termination of pregnancy refused', *Lancet* 1, 1059 (1971).

226. Dytrych et al., p. 165

284. Clark et al. followed up 109 patients refused in the UK during 1961–64 and found that over one-third had aborted elsewhere or ‘spontaneously’, leading the authors to comment:

It seems that a determined, desperate woman will somehow abort. If she is so determined, and impervious to her doctor’s advice to the contrary, is it then better for him to acquiesce? In other words, would not her health be best maintained by leaving the final decision to her?²²⁷

285. Pare and Raven followed up 120 refused requests for abortion and found that seventy-three had gone to term and forty-three or one-third had obtained an abortion elsewhere. An additional four of those who went to term had premature deliveries and/or stillborn children.

286. Of the seventy-three who went to term, fourteen had had the baby adopted or fostered; sixteen still regretted the child and frequently admitted to feelings of resentment towards it; of these, six had persistent depressive and/or phobic reactions. The stress of continuing the pregnancy appeared to be much greater in single women and in those estranged from their husbands. Four such patients were admitted to hospital due to the severity of their symptoms, one on several occasions over a period of 3 years.

287. Of those receiving legal termination, all except two had few regrets and these two were terminated largely on account of their husbands’ mental illness. Of the others, ‘the most striking general impression was the lack of serious psychological sequelae’; mild feelings of guilt and loss were common, but did not last long.²²⁸

288. Todd’s study followed up thirty-two cases of patients referred for psychiatric assessment, but refused abortion. Of these, twelve of the patients or over one-third did not go to term (one possible spontaneous), twenty went to term. Of these, fifteen kept their children, four had them adopted out, and one was stillborn; twenty-two of these cases were reported to have made a good adjustment, but unfortunately the authors do not tell us which did not.²²⁹

289. Hamil and Ingram found that of forty-eight refusals, only twenty-five went to term. Of these, seventeen kept the baby and six were adopted out, with the outcome for two still in doubt at the time of the follow-up. Twenty-three of the refused patients accepted the situation, one was unsure, and one was bitter and resentful. Among the twenty-five, there were three cases regarded as having definite psychiatric sequelae, four were on psychotropic drugs, and four experienced significant social problems, in the opinion of the authors. They conclude, on the basis of a comparison with patients not refused:

While psychiatric sequelae are uncommon in terminated and unterminated patients they are marginally more frequent in those refused.²³⁰

290. A report on the longest term study of refused abortion and its effect on the women involved was published by Kerstin Hook in 1963.²³¹ She had studied 249 representative women refused abortion in 1948 with an 18-month observation period and follow-ups at 7½ to 12 years.

227. M. Clark, I. Forstner, D. A. Pond & R. F. Tredgold, ‘Sequelae of unwanted pregnancy’, *Lancet*, 31 August 1968, p. 503.

228. C. M. B. Pare and Hermione Raven, *Lancet* (1970), p. 636.

229. Todd et al. (1971), pp. 489–95.

230. Evelyn Hamil & I. M. Ingram, ‘Psychiatric and social factors in abortion decision’, *British Medical Journal*, 9 February 1974, pp. 489–95.

231. Kerstin Hook, ‘Refused abortion’, *Acta Psychiatrica Scandinavica*, Supplementum 168, 39 (1963), Munksgaard Copenhagen, pp. 123 ff.

291. Of the 249 women, 86 per cent went to term, 14 per cent did not. Of the 11 per cent known to have had illegal abortions nearly half had been hospitalised thereafter. The unmarried and those in conflict with or deserted by their partner were twice as likely to seek illegal abortion as those in stable marriages. Of the 86 per cent who went to term, 69 per cent had originally kept the children, but by the later follow-up only 59 per cent still had their children with them. A few of the children had died.²³²

292. Of the sample at the late follow-up, 73 per cent were satisfied with their situation, but of these only 22 per cent thought the refusal had been justified. Twenty-seven per cent of the sample would still have preferred a legal abortion.²³³

293. The support of the male partner proved to be a crucial factor in whether the outcome was satisfactory or not.²³⁴

294. Hook summarises:

Among those who had adjusted themselves to the situation there was a group of women (23 per cent) who had accepted the pregnancy after the refusal and had been able to handle the situation satisfactorily. Another, larger group of women (53 per cent) had finally adjusted themselves after having had a variety of insufficiency reactions during the observation period. For 24 per cent of the women the situation had been so unfavourable that symptoms of insufficiency which had arisen within 18 months of the application were still present at the time of the follow-up. Sick leave because of mental ill health occurred within 18 months in 7 per cent and at a later date in 13 per cent . . . significantly higher than in the series of women granted permission for therapeutic abortion. Poor adjustment at the follow-up was noted in 35 per cent of those first recommended then turned down, compared with 18 per cent of those not recommended at first.

. . . among those who gave birth 69 per cent had adjusted themselves and were satisfied with their situation. Thirty-one per cent were dissatisfied . . . in these cases it may be presumed that the environment for the child would be unfavourable.²³⁵

295. Hook concludes:

Judging by the frequency of poor adjustment and mental sequelae in the follow-up material, a request for legal abortion, especially by women with mental deviations, suggests the presence of conflicts in the environment and mental frailty likely to cause insufficiency reactions when the women are subjected to the increased burden and stress implied in an unwanted pregnancy.²³⁶

296. An Aberdeen study²³⁷ assessed two groups of women, those who had ended their pregnancies by induced abortion, and those who had been refused abortion. They found the aborted group less depressed and hostile than the women who carried an unwanted pregnancy to term. This was particularly noticeable in the unmarried women; 18 months later:

One in nine in the abortion group was rated as depressed as compared with one in four of those continuing the pregnancy—an effect which approached the 5 per cent level of significance.

The authors concluded that the mental health of a woman faced with an unwanted pregnancy is improved more by an abortion than by going to term.

232. *ibid.*, p. 127.

233. *ibid.*, p. 129.

234. *ibid.*, p. 129.

235. *ibid.*, pp. 130–1.

236. *ibid.*, p. 131.

237. C. McCance, P. C. Olley, V. Edward, 'Long-term psychiatric follow-up' in G. Horobin (ed.), *Experience with abortion* (Uni. of Cambridge Press, 1973).

Adoption

297. Adoption of children born of unwanted pregnancies may be the best solution for the children concerned. But there needs to be more research into the subsequent psychological effects on mothers who have given up their children in this manner.

298. The Commission received testimony from Dr Peter Hoopman, obstetrician and gynaecologist of Adelaide. It was his growing awareness of the heartache and mental disturbance involved following the necessity for his young patients to give up their babies which changed his personal stance on the question of abortion. He said in testimony:

But what changed my whole attitude after much soul searching was the fact that five girls in that first year had been refused termination and had subsequently had their babies and had given them up for adoption. They were referred back by psychiatric hospitals after 1 to 3 months of treatment, for acute depression. Nearly all of them were for discharge the following day, and to have family planning advice. Nearly all of them I thought should be put straight back into hospital.²³⁸

299. He was particularly shocked at the loss to society of a promising trainee nurse in her final year. Of abortion he now believes 'that it is not legalised murder; it is justifiable homicide'.

300. Other medical personnel have expressed similar opinions. Lidz has found much incidence of psychological trauma in association with the adoption of babies: 'The mother, though willing to consider destruction of the foetus, is usually unable to consider giving up the baby for adoption if it is to be born.'²³⁹

301. Harold Rosen feels quite strongly about what he sees as the cruelty involved in encouraging women to bear children they cannot rear:

No one in the technical literature has stressed the heartlessness, the cruelty, and the sadism that the pregnant woman so frequently senses—perhaps correctly, perhaps mistakenly—when physician, minister, or lawyer suggests to her that she carry the child to term and then hand it over, never to see it again, to someone else to rear . . . During the past 19 years, I have seen only three patients for whom 'farming out' a child for adoption would not have been emotionally traumatic and psychiatrically contra-indicated. For twenty-nine patients who came into psychiatric treatment within 1 to 4 years after they had accepted this recommendation, what they considered the abandoning of their infants required careful, cautious, and extensive therapeutic consideration.²⁴⁰

238. Evidence, p. 1314, Dr P. Hoopman.

239. Theodore Lidz, 'Reflections of a psychiatrist' in Harold Rosen (ed.), *Abortion in America* (Beacon Press, Boston, 1967), p. 280.

240. H. Rosen, 'A case study in social hypocrisy', *ibid.*, p. 310.

D. T. Smith (ed.), *Abortion and the law* (Western Reserve University Press, Cleveland, 1967), p. 82; see also Pare & Raven, p. 635.

Additional references

1. M. Buvinic, C. S. Adams, G. S. Edgecombe, M. Koch-Weser, *Women and world development—an annotated bibliography* (American Association for the Advancement of Science, Overseas Development Council, Washington, 1976) XII, 162.

2. I. Tinker & M. B. Bramsen, *Women and world development* (papers from AAAS Seminar, Mexico City, June 1975) XII, 225.

Abortion

The termination of a pregnancy before the foetus has attained viability, i.e. become capable of independent extra-uterine life. Abortion may be spontaneous or induced. The World Health Organisation (1950) defined viability as occurring at 28 weeks gestation, or 30 weeks from the first day of the last menstrual period. However, more recent WHO committees would declare an upper limit of 20 and 22 weeks, to conform with recent advances in medical technology and experience.

Abortion—criminal or illegal

An induced abortion which takes place without the sanction of the law.

Abortion—incomplete

A term for an abortion when the contents of the uterus are incompletely emptied; it may be either induced or spontaneous, and it is often difficult to determine which is the case.

Abortion—induced

Abortions deliberately initiated with the aim of terminating a pregnancy.

Abortion—legal

An induced abortion performed within the limits prescribed by law.

Abortion—other than legal

A term used to include all those abortions not coming within the legal framework. They may include spontaneous, criminal, illegal and quasi-legal abortions.

Abortion—septic

An abortion of any kind which is followed by an infection of a serious or life-threatening nature.

Abortion—spontaneous

Abortions occurring naturally without deliberate intent—‘miscarriages’. It is often difficult to differentiate spontaneous from illegally induced abortion.

Abortion—therapeutic

The use of this term varies, but here it is used to describe a legally induced abortion performed in a period when legal abortions were restricted to those women with serious medical indications, based on the condition of the foetus and/or mother.

Amniocentesis

A process whereby a sample of amniotic fluid is withdrawn in order to conduct tests to determine whether the foetus will develop into a child with congenital deformity or other abnormalities.

Amniotic fluid

Fluid surrounding the foetus in the uterus. This fluid is contained within the amniotic sac.

Cannula

A hollow tube or catheter which is inserted into the cervix for the purpose of withdrawing uterine contents; originally made of metal or glass, they now tend to be plastic and disposable.

Case fatality rate

The number of deaths occurring in a given number of cases.

Cervix

The entrance to the womb or uterus to be found at the top of and within the vagina.

Cervical incompetence

Inability of the internal cervical sphincter (or muscle) to hold the conceptus in place, producing spontaneous abortion or premature labour. The condition is fairly rare and it can be identified and corrected by suturing (repairing by stitching).

Cervico-isthmic incompetence

Synonymous with cervical incompetence. The internal muscular sphincter of the cervix is torn during forcible dilation (either abortion or delivery) and there is consequent failure to keep the canal tightly closed.

Conceptus

The contents of the uterus in the early stages of pregnancy. The products of conception: zygote, embryo or foetus.

Contra-indication

A reason or set of reasons why a certain procedure should not be carried out or drug administered. See 'Indication'.

Dilatation and curettage

A method of inducing abortion in which the cervix is dilated or stretched open, and the conceptus removed using a curette, or spoon-shaped instrument. Abbreviated to D & C.

Duration of pregnancy

Length of pregnancy is calculated either by gestation period, that is the time from the day of conception, or from the first day of the last menstrual period, which would add approximately an additional 2 weeks. The latter is referred to as LMP and should give a more consistently accurate calculation. However, it is not impossible for a pregnant woman to experience something like a period after conception, so the LMP date is not infallible. Clinical estimates, or calculation by manual examination and 'feel' of size, are only as reliable as the experience of the estimator. As the foetus may grow at different rates in different women, the clinical estimate by an experienced operator may be the most reliable guide to the appropriate method to be used if an induced abortion is under consideration.

Ectopic pregnancy

A pregnancy which occurs outside the uterus, generally in the fallopian tube.

Endocrinology

The study of hormones, their production, nature and effects.

Endometriosis

Abnormal deposits of fragments of the mucous membrane lining of the uterus in other sites of the body, usually the pelvic organs, or scars after operations on the uterus.

Fallopian tubes

Two narrow tubes attached at one end to the uterus, with the other openings unattached but lying close to the ovary. These tubes conduct the ova (female eggs) from the ovaries to the interior of the uterus.

Fecundity

The physiological capacity to bear children.

Fertility

Actual number of births in a nation or an individual.

Fertility control

Any method or practice which limits or controls the numbers of children born.

Foetus

The potential infant growing in the uterus; some restrict this term to the period from about 6 weeks to 20 weeks. After that, it is referred to as 'an unborn infant'. Before 6 weeks it is a 'zygote' for the first 10 days; then an 'embryo'. All these terms vary with the conceptual orientation of the user.

Gestation period

The duration of pregnancy as estimated from the day of conception.

Haemorrhage

An abnormal loss of blood.

Hormones

Chemical messengers within the body.

Hysterectomy

An operation to remove the uterus.

Hysterotomy

An operation which involves opening the abdomen and uterus to remove a foetus.

Immunoglobulin treatment

An injection given to a woman with RH-negative blood factor so that in future pregnancies the antibodies in her blood will not damage the foetus. See RH-negative factor.

Indication

In the medical sense—the reason or set of reasons for a certain course of action.

Induction

Within the context of pregnancy and abortion the term is used to describe an attempt to initiate labour.

Interception of pregnancy

Used to describe a process or method of inducing a late menstrual period before pregnancy is confirmed. It may be an oral agent or menstrual regulation.

Intra-amniotic injection

An injection into the fluid-filled sac surrounding the foetus.

Intra-uterine instillation

The introduction of a liquid into the uterus drop by drop.

Insufficiency

A term translated from Scandinavian psychomedical literature which indicates that an individual is not functioning well emotionally, psychologically or socially. The condition is not severe enough to warrant hospitalisation.

In utero

Within the uterus.

Laparoscopic sterilisation

A method of female sterilisation which involves cutting two small incisions in the abdomen and closing off small sections of the fallopian tubes. The laparoscope or illuminated telescope is used to visualise the abdominal cavity.

Laparotomy

An incision through the abdominal wall.

LMP

First day of the last menstrual period; used in determining the length of pregnancy.

Menstrual regulation

A method used to empty the contents of the uterus at or before a period is overdue and before pregnancy has been diagnosed.

Metabolic

To do with the process of synthesising and breaking down foodstuffs for the use of the body.

Miscarriage

A spontaneous abortion.

Morbidity

Problems, diseases or accidents in association with induced abortion, pregnancy or childbirth.

Mortality

Having to do with death.

Mortality rate

The number of deaths occurring in a given number of cases.

Neonate

A newborn infant.

Nullipara

A woman who has not borne a child.

Paranoia

In its extreme form a serious mental illness in which the sufferer believes others are plotting against him or her, sometimes causing violent reactions. In a mild form it involves delusions about others.

Paracervical block

A local anaesthetic administered by needle at several positions around the cervix.

Parity

Describes the number of viable foetuses a woman has delivered (gravidity refers to the number of pregnancies). This would apply to any foetus which survives in utero beyond the twentieth week.

Phlebitis

Inflammation of a vein.

Placenta

The thick spongy tissue which connects the embryo with the inner surface of the uterus by means of the umbilical cord. Through this cord the embryo receives its nourishment.

Placenta praevia

A placenta so placed that serious haemorrhage occurs during late pregnancy necessitating massive transfusions and sometimes caesarean section delivery (surgical opening of the abdomen to remove the infant).

Post-partum

After childbirth.

Prima facie

At first sight; on the face of it.

Primipara

A woman bearing, or giving birth to, her first child.

Prostaglandin induction

The initiation of labour through the introduction of a particular chemical compound of fatty acids into the uterus.

Psycho-analysis

Psychological theories developed by Freud concerned primarily with the conflicts between infantile instinctual striving and parental or social demand. In the context of the study mentioned in this report students of psycho-analysis predicted disturbance following abortion based on theories of motherhood as instinctual behaviour.

Psycho-obstetrics

A specialised field of psychiatry which deals with the mental health of pregnant and post-partum women.

Psychopathology

The study of mental illness.

Psychosis

A serious mental illness in which the personality is affected, sometimes necessitating hospitalisation.

Psychosocial

The interaction between social influence and psychological response.

Psychosomatic

The interaction between mind and body.

Psychotic parturient

A woman who has developed a serious mental illness after childbirth.

Psychotropic

To do with drugs which have an affect on the mind; generally used to relieve symptoms of anxiety or depression.

Puerperal depression

Depression following childbirth.

Puerperal psychosis

A psychotic reaction occurring during pregnancy or after birth.

Puerperium

The period of approximately 6 weeks after childbirth.

Pyrexia

Fever; elevation of body temperature above the normal.

Quickening

The stage of pregnancy when movement of the foetus in the uterus can first be felt by the mother.

Rh-negative factor

A characteristic of blood present in approximately 15 per cent of Caucasians. Women with this blood factor bearing a child with a positive blood factor may produce defences in the body against it which in a subsequent pregnancy may cause blood damage to an Rh-positive foetus.

Saline induction

The deliberate initiation of labour by replacement of part of the amniotic fluid with saline solution.

Salpingitis

Infection of the fallopian tubes; generally a serious infection.

Schizophrenia

A category of serious mental illness.

Sepsis

Severe infection.

Suction curettage

Also known as vacuum aspiration or vacuum curettage.

Tetracycline

An antibiotic used against infections.

Trimester

A pregnancy is divided into three periods of time of approximately 12 weeks' duration each. The second trimester is sometimes referred to as the mid-trimester.

Tubal ligation

Sterilisation of the female by tying the fallopian tubes.

Vacuum aspiration or vacuum curettage

A method of inducing abortion in which the cervix is dilated or opened and the contents of the uterus withdrawn by means of suction. Abbreviated to VA.

Viability

In the context of pregnancy and abortion—the quality of having life or capability of living ex utero, outside the mother's body.

Annexe IV.Q

Sequelae of abortion

Report of survey of hospital and clinic morbidity

Research report no. 2

Royal Commission on Human Relationships

Survey of hospital and clinic morbidity

1. The survey was carried out during April and June 1976. Three public hospitals, three clinics and two private hospitals in three major centres took part. They were asked to fill out a questionnaire for all abortion patients during a 6-week period; 2788 completed questionnaires were returned. A copy of the questionnaire form is attached.

2. Care was taken to follow up as many patients as possible, to ensure that post-operative complications would be recorded accurately. Two of the clinics used special forms which were forwarded to referring doctors; the other clinic found its regular form could be slightly adapted to fit in with the needs of the Commission's assessment criteria.

3. It was, however, not possible to get 100 per cent follow-up of the patients included in this survey. For example, one of the hospitals regularly saw its abortion patients 4 weeks after the procedure, which meant some minor complications which might have been reported by patients would not have been included.

Table IV.Q.1 Abortion patients surveyed

| | % Number | |
|--------------------|----------|-------|
| No follow-up | 35.9 | 1 003 |
| Partial follow-up | 17.5 | 490 |
| Complete follow-up | 46.4 | 1 295 |
| | | 2 788 |

4. There was no follow-up information for 35.9 per cent of the patients, as indicated in table IV.Q.1, which will account for the fact that base line figures for post-operative complications will vary. Other variations in base line figures are due to omissions on the part of medical personnel in filling out the forms.

5. It must be stressed, however, that there were no omissions found in the area of operative complications, as any forms with blanks in these questions were returned to the facilities for completion.

6. It should also be noted that patients experiencing post-abortion difficulties are more likely to report back than those free of complications, hence symptoms found in those with some or complete follow-up may be slightly over-representative of the group as a whole.

7. In a series of 2788 patients undergoing legal abortion in the 6-week period surveyed, there were no deaths. The findings of the survey are summarised in the following tables:

Table IV.Q.2 Age of patient

| Age | Number | % |
|-------------|--------|------|
| Under 16 | 129 | 4.6 |
| 16-19 | 697 | 25.1 |
| 20-24 | 831 | 29.9 |
| 25-29 | 574 | 20.7 |
| 30-34 | 277 | 10.0 |
| 35-39 | 194 | 7.0 |
| 40-44 | 65 | 2.3 |
| 45 and over | 12 | 0.4 |
| | 2 779 | |

Table IV.Q.3 Marital status

| | Number | % |
|--------------------|--------|------|
| Married | 982 | 35.4 |
| Single | 1467 | 52.9 |
| Divorced/separated | 246 | 8.9 |
| Widowed | 15 | 0.5 |
| De facto | 61 | 2.2 |
| | 2 771 | |

Table IV.Q.4 Previous pregnancies, births and abortions

| | Pregnancies | | Births | | Abortions | |
|---|-------------|------|--------|------|-----------|------|
| | No. | % | No. | % | No. | % |
| 0 | 1 335 | 48.1 | 1 588 | 57.6 | 2 278 | 82.9 |
| 1 | 477 | 17.2 | 378 | 13.7 | 389 | 14.2 |
| 2 | 398 | 14.3 | 453 | 16.4 | 58 | 2.1 |
| 3 | 278 | 10.0 | 198 | 7.2 | 13 | 0.5 |
| 4 | 148 | 5.3 | 88 | 3.2 | 4 | 0.1 |
| 5 | 91 | 3.3 | 35 | 1.3 | 5 | 0.2 |
| 6 | 36 | 1.3 | 16 | 0.6 | 1 | 0.0 |
| 7 | 10 | 0.4 | 3 | 0.1 | | |
| 8 | 5 | 0.2 | | | | |
| | 2 778 | | 2 759 | | 2 748 | |

Table IV.Q.5 Length of pregnancy

| Weeks | From last menstrual period | | By clinical estimate | |
|---------|----------------------------|------|----------------------|------|
| | Number | % | Number | % |
| up to 8 | 1 143 | 41.4 | 1 214 | 43.8 |
| 8-10 | 1 023 | 37.1 | 1 020 | 36.8 |
| 11-12 | 341 | 12.4 | 312 | 11.2 |
| 13-14 | 89 | 3.2 | 99 | 3.6 |
| over 14 | 116 | 4.2 | 127 | 4.6 |
| unknown | 47 | 1.7 | 2 | 0.1 |
| | 2 759 | 100 | 2 774 | 100 |

Table IV.Q.6 Method of primary procedure

| | Number | % |
|-------------------------|--------|------|
| Vacuum aspiration | 2 684 | 96.3 |
| D & C | 19 | 0.7 |
| Saline induction | 28 | 1.0 |
| Prostaglandin induction | 5 | 0.2 |
| Urea induction | 3 | 0.1 |
| Hysterotomy | 2 | 0.1 |
| Two-stage | 46 | 1.7 |
| | 2 787 | 100 |

Table IV.Q.7 Anaesthetic used

| | Number | % |
|----------|--------|------|
| General | 2 161 | 77.7 |
| Local | 601 | 21.6 |
| Epidural | 4 | 0.1 |
| Other | 17 | 0.6 |
| | 2 783 | 100 |

Table IV.Q.8 Sterilisation and IUD

| | Number | % | Base |
|----------------------------|--------|------|-------|
| Sterilisation | 57 | 2.0 | 2 784 |
| IUD (removal or insertion) | 413 | 14.9 | 2 780 |

Table IV.Q.9 Complications at time of primary procedure

| | Number | % | Base |
|-----------------------|--------|------|-------|
| Cervical tearing | 0 | 0 | 2 788 |
| Perforation reported | 4 | 0.1 | 2 788 |
| suspected | 4 | 0.1 | |
| Blood loss | | | |
| 0-300 ml | 2 771 | 99.4 | 2 788 |
| 301-600 ml | 14 | 0.5 | |
| over 600 ml | 3 | 0.1 | |
| Transfusion necessary | 4 | 0.1 | 2 788 |

Table IV.Q.10 Post-operative complications (base 1785, 64 per cent)

| | Number | % | base |
|--|--------------------|------|-------|
| Retained products | 30 | 1.7 | |
| Retained products suspected | 39 | 2.2 | 1 779 |
| Repeat curettage | 57 | 3.2 | 1 780 |
| Blood loss after primary procedure: | | | |
| 0-300 ml | 1 763 | 99.4 | 1 774 |
| 301-600 ml | 6 | 0.3 | |
| over 600 ml | 1 | 0.1 | |
| Temperature | | | |
| (1) 37.6° more than once in 12 hours | 55 | 3.5 | 1 551 |
| (2) 37.6° more than once in 48 hours | 28 | 1.8 | 1 517 |
| (3) 37.6° more than once in 49 or more hours | 22 | 1.5 | 1 517 |
| Readmitted or transferred to hospital | 26 | 1.5 | 1 782 |
| Hospital stay 1-3 days | 394 ^(a) | 22.2 | |
| 4-6 days | 22 | 1.2 | 1 771 |
| 7 or more | 13 | 0.7 | |
| Other complications | 49 | 1.8 | 2 788 |

(a) Presumably this would include patients done on an overnight stay basis in hospital who were not entered as retained or readmitted.

- 8 We were informed by some of the facilities involved in the survey that an influenza epidemic was in progress at the time, hence some of the reported fevers may not be related to the abortion procedure.
- 9 A question on administration of antibiotics has been eliminated, as two clinics give antibiotic coverage fairly routinely; hence it is no indication of post-abortion complications.
- 10 Similarly a question on retention in hospital was misunderstood and would include routine hospital stays; it has also been eliminated (see table IV.Q.11).
- 11 The complication rates should be seen in the perspective of the gestation period and method used for the procedure (see table IV.Q.12 and IV.Q.13).

Other factors

12 The survey showed a tendency for young women to have their pregnancy terminated at a later stage than older women (see table IV.Q.14). The results also show that a number of teenagers had had previous abortions (see table IV.Q.15).

13 We stress that these are preliminary results as the data were not available in time to complete the analyses. It is hoped that further analyses will be carried out and that further surveys will be carried out using this survey as a pilot model.

Table IV.Q.11 Complications by type of facility

| | Type of facility | | | | | |
|---|------------------|------------|-----------|-------------|-------------------|------------|
| | Public hospitals | | Clinics | | Private hospitals | |
| | No. | % of total | No. | % of total | No. | % of total |
| Complications at time of primary procedure— | | | | | | |
| | | | Base line | | Base line | Base line |
| Perforation: | | | | | | |
| reported | 1 | 0.3 (334) | 3 | 0.1 (2 379) | 0 | 0 (68) |
| suspected | 2 | 0.6 | 2 | 0.1 | 0 | 0 |
| Blood loss: | | | | | | |
| 301–600 ml | 7 | 2.1 | 6 | 0.3 | 1 | 1.5 |
| over 600 ml | 1 | 0.3 | 0 | 0 | 2 | 2.9 |
| Transfusion required | 2 | 0.6 | 2 | 0.1 | 0 | 0 |
| Post-operative complications— | | | | | | |
| Retained products: | | | | | | |
| reported | 20 | 6.0 | 10 | 0.4 | 0 | 0 |
| suspected | 8 | 2.4 | 30 | 1.3 | 1 | 1.5 |
| Repeat curettage | 25 | 7.5 | 30 | 1.3 | 2 | 2.9 |
| Blood loss after primary procedure: | | | | | | |
| 301–600 ml | 2 | 0.6 | 4 | 0.2 | 0 | 0 |
| over 600 ml | 0 | 0 | 1 | 0 | 0 | 0 |
| Post-operative fevers: | | | | | | |
| 37.6° more than once in 12 hours | 8 | 2.4 | 45 | 1.9 | 0 | 0 |
| 37.6° more than once in 48 hours | 4 | 1.2 | 21 | 0.9 | 0 | 0 |
| 37.6° more than once in 49 or more hours | 4 | 1.2 | 18 | 0.8 | 0 | 0 |
| Patient readmitted or transferred to hospital | 19 | 5.7 | 6 | 0.3 | 1 | 1.5 |
| Stay 4–6 days | 17 | 5.1 | 3 | 0.1 | 1 | 1.5 |
| 7 or more days | 10 | 3.0 | 2 | 0.1 | 0 | 0 |
| Other complications | 10 | 3.0 | 39 | 1.6 | 0 | 0 |

Table IV.Q.12 Gestation period and method by facility

| Length of pregnancy | Public hospitals | | | | Clinics | | | | Private hospitals | | | |
|---------------------|------------------|------|-------------------|------|---------|------|-------------------|------|-------------------|------|-------------------|------|
| | By LMP | | Clinical estimate | | By LMP | | Clinical estimate | | By LMP | | Clinical estimate | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| Up to 8 weeks | 164 | 49.1 | 160 | 47.9 | 949 | 39.9 | 1 017 | 42.7 | 28 | 41.2 | 35 | 51.5 |
| 8-10 weeks | 70 | 21.0 | 93 | 27.8 | 918 | 38.6 | 902 | 37.9 | 32 | 47.1 | 24 | 35.3 |
| 11-12 weeks | 22 | 6.6 | 35 | 10.5 | 316 | 13.3 | 272 | 11.4 | 3 | 4.4 | 3 | 4.4 |
| 13-14 weeks | 5 | 1.5 | 6 | 1.8 | 82 | 3.4 | 91 | 3.8 | 3 | 4.4 | 4 | 5.9 |
| Over 14 weeks | 55 | 16.5 | 40 | 12.0 | 82 | 3.4 | 86 | 3.6 | 2 | 2.9 | 2 | 2.9 |
| Unknown | 18 | 5.4 | | | 33 | 1.4 | 12 | 0.5 | | | | |
| | 334 | | 334 | | 2 380 | | 2 380 | | 68 | | 68 | |

Table IV.Q.13 Method used by facility

| Method | Public hospitals | | | Clinics | | | Private hospitals | | |
|-------------------------|------------------|-------|-------|---------|-------|---------|-------------------|-------|------|
| Vacuum aspiration | 290 | 86.8% | (334) | 2 325 | 97.8% | (2 379) | 64 | 94.1% | (68) |
| D & C | 6 | 1.8% | | 9 | 0.4% | | 4 | 5.9% | |
| Saline induction | 28 | 8.4% | | 0 | | | 0 | | |
| Prostaglandin induction | 5 | 1.5% | | 0 | | | 0 | | |
| Urea induction | 3 | 0.9% | | 0 | | | 0 | | |
| Hysterotomy | 1 | 0.3% | | 0 | | | 0 | | |
| Hysterectomy | 1 | 0.3% | | 0 | | | 0 | | |
| Two-stage | 0 | | | 45 | 1.9% | | 0 | | |

Table IV.Q.14 Length of pregnancy related to age of patient

| Weeks since last menstrual period | All patients | Patients 16-19 | Patients under 16 |
|-----------------------------------|--------------|----------------|-------------------|
| | % | % | % |
| Up to 8 | 41.4 | 32.9 | 29.7 |
| 8-10 | 37.1 | 39.0 | 30.5 |
| 11-12 | 12.4 | 15.5 | 12.5 |
| 13-14 | 3.2 | 4.9 | 7.8 |
| Over 14 | 4.2 | 6.0 | 16.4 |
| Unknown | 1.7 | 1.6 | 3.1 |

Table IV.Q.15 Previous abortions related to age

| Age | None | One or more | 1 | 2 | 3 | 4 or more |
|----------|------|-------------|-----|-----|-----|-----------|
| | % | % | No. | No. | No. | No. |
| All ages | 82.9 | 17.0 | 470 | | | |
| Under 16 | 94.5 | 5.4 | 7 | 7 | .. | .. |
| 16-19 | 94.6 | 5.4 | 37 | 34 | 3 | .. |
| 20-24 | 81 | 19.0 | 155 | 140 | 10 | 3 |
| 25-29 | 73.9 | 26.0 | 147 | 116 | 23 | 3 |
| 30-34 | 74.4 | 25.6 | 70 | 51 | 14 | 4 |
| 35-39 | 77.7 | 22.3 | 42 | 32 | 6 | .. |
| 40-44 | 84.4 | 15.6 | 10 | 7 | 2 | .. |
| 45+ | 83.3 | 16.7 | 2 | 2 | .. | .. |

Questionnaire

Patient
identification

(1 - 4) (5)

Office use only

For use of medical personnel only.

(All information is strictly anonymous and confidential.)

How to complete this questionnaire. Please read carefully.

Complete *one* questionnaire per patient. For each question circle the appropriate response number, or write in the number required. Each question requires only one response. Please ensure that *all* questions are answered.

| | | Office use | | | Office use |
|-------|-----------------------------------|---------------|--------|---|---------------|
| Q. 1. | Date of operation | | | 11 - 12 weeks | 3 |
| | day month | | | 13 - 14 weeks | 4 |
| | | | | 14 + weeks | 5 |
| | | | | Not known | 6 |
| Q. 2. | Age of patient | 6 | Q. 8. | Method of primary procedure | 13 |
| | - - 16 | 1 | | Vacuum aspiration (suction) | 1 |
| | 16 - 19 | 2 | | Dilatation and curettage | 2 |
| | 20 - 24 | 3 | | Saline induction | 3 |
| | 25 - 29 | 4 | | Prostaglandin induction | 4 |
| | 30 - 34 | 5 | | Urea induction | 5 |
| | 35 - 39 | 6 | | Hysterotomy | 6 |
| | 40 - 44 | 7 | | Hysterectomy | 7 |
| | 45 + | 8 | | | |
| Q. 3. | Marital status | 7 | Q. 9. | Anaesthetic used | 14 |
| | Married | 1 | | General | 1 |
| | Single | 2 | | Local | 2 |
| | Divorced/separated | 3 | | Epidural | 3 |
| | Widowed | 4 | | Other | 4 |
| | De facto | 5 | | None | 5 |
| Q. 4. | No. of previous pregnancies | () 8 | Q. 10. | Did the patient have diagnosed pre-existing condition(s)? | 15 |
| Q. 5. | No. of previous live births | () 9 | | Yes | 1 |
| Q. 6. | No. of previous induced abortions | () 10 | | No | 2 |
| Q. 7. | Length of present pregnancy | 11 | | Unknown | 3 |
| | (a) From LMP | | Q. 11. | Additional procedures at time of primary procedure | 16 |
| | - - 8 weeks | 1 | | Sterilisation | |
| | 8 - 10 weeks | 2 | | Yes | 1 |
| | 11 - 12 weeks | 3 | | No | 2 |
| | 13 - 14 weeks | 4 | | IUD | 17 |
| | 14 + weeks | 5 | | Yes | 1 |
| | Not known | 6 | | No | 2 |
| | (b) By clinical estimate | 12 | | Other | 18 |
| | - - 8 weeks | 1 | | Yes | 1 |
| | 8 - 10 weeks | 2 | | No | 2 |

| | | Office use | | Office use |
|--------|--|---------------|---|---------------|
| Q. 12. | Complications | | Temperature of 37.6° on two or more occasions up to 48 hours | 27 |
| | (a) At the time of primary procedure | | Yes | 1 |
| | Cervical tearing | 19 | No | 2 |
| | Yes | 1 | | |
| | No | 2 | Temperature of 37.6° on two or more occasions up to and beyond 49 hours | 28 |
| | Perforation | 20 | Yes | 1 |
| | Yes | 1 | No | 2 |
| | No | 2 | | |
| | Suspected | 3 | Antibiotics given | 29 |
| | Blood loss | 21 | Yes | 1 |
| | 0 – 300 ml | 1 | No | 2 |
| | 301 – 600 ml | 2 | | |
| | 600 + ml | 3 | Patent retained in hospital | 30 |
| | Transfusion | 22 | Yes | 1 |
| | Yes | 1 | No | 2 |
| | No | 2 | | |
| | (b) Post-primary procedure | | Patient readmitted or transferred to hospital | 31 |
| | Retained products | 23 | Yes | 1 |
| | Yes | 1 | No | 2 |
| | No | 2 | Length of stay in hospital | 32 |
| | Suspected | 3 | 1 – 3 days | 1 |
| | Repeat curettage | 24 | 4 – 6 days | 2 |
| | Yes | 1 | 7 + days | 3 |
| | No | 2 | N/A | 4 |
| | Blood loss | 25 | Death of patient | 33 |
| | 0 – 300 ml | 1 | Yes | 1 |
| | 300 – 600 ml | 2 | No | 2 |
| | 600 + ml | 3 | | |
| | Temperature of 37.6° on two or more occasions up to 12 hours | 26 | Other complications | 34 |
| | Yes | 1 | Yes | 1 |
| | No | 2 | No | 2 |
| | | | No complications | 35 |
| | | | Yes | 1 |
| | | | No | 2 |

Signature of attending physician or authorised agent:

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1

2

3

4

5

Name and address of
hospital

Questionnaire
filled in by

| | | | | |
|------------------|-------------|--------------------------|-------------------------------|---|
| This hospital is | Private | <input type="checkbox"/> | Tick all which apply | 6 |
| | Public | <input type="checkbox"/> | | |
| | General | <input type="checkbox"/> | | 7 |
| | Specialised | <input type="checkbox"/> | | |

Please describe
specialisation:

Non-denominational

8

Affiliated to a
religious organisation

HOW TO FILL OUT THIS QUESTIONNAIRE

If termination of pregnancy operations *are not* carried out at your hospital
answer questions 1 and 2 in Section A and questions 41–44 in Section F.
If termination of pregnancy operations *are* carried out at your hospital
please begin at *question 3 in Section B* and answer *all* subsequent questions.
Please ensure that *all questions are answered*, unless an instruction to the
contrary appears against a question. Please answer questions by ticking the
appropriate boxes, or by writing in an answer where requested.

SECTION A. FOR HOSPITALS NOT PERFORMING TERMINATIONS

Q. 1. Please indicate the reasons why terminations are not performed at your hospital.

9

Q. 2. If patients are referred elsewhere for terminations, please indicate the type of agency referred to:

| | | | |
|----------------------------------|--------------------------|-------|----|
| public hospital | <input type="checkbox"/> | Tick | 10 |
| private hospital | <input type="checkbox"/> | all | 11 |
| private clinic | <input type="checkbox"/> | which | 12 |
| private doctor | <input type="checkbox"/> | apply | 13 |
| other (specify) | <input type="checkbox"/> | | 14 |
| (_____) | | | |
| patients are not referred | <input type="checkbox"/> | | |
| (Please go to Section F, Q. 41.) | | | |

SECTION B. FOR HOSPITALS PERFORMING TERMINATIONS

Q. 3. What are the grounds for termination of pregnancy at your hospital?

| | | | |
|--|--------------------------|-------|----|
| medical | <input type="checkbox"/> | Tick | 15 |
| psychological | <input type="checkbox"/> | all | 16 |
| social and economic | <input type="checkbox"/> | which | 17 |
| no policy: terminations are at the doctor's discretion | <input type="checkbox"/> | apply | 18 |
| other (specify) | <input type="checkbox"/> | | 19 |
| (_____) | | | |
| (_____) | | | |

Q. 4. Which procedures for 1st and 2nd trimester termination are used at this hospital? Indicate with * those most frequently used.

| | | | |
|---|--------------------------|-------|----|
| 1st trimester | | | |
| vacuum aspiration | <input type="checkbox"/> | Tick | 20 |
| D & C | <input type="checkbox"/> | all | 21 |
| other (specify) | <input type="checkbox"/> | which | 22 |
| (_____) | | apply | |
| (_____) | | | |
| 2nd trimester | | | |
| intra-amniotic infusion prostaglandins | <input type="checkbox"/> | | 23 |
| intra-amniotic infusion saline | <input type="checkbox"/> | | 24 |
| intra-amniotic infusion urea | <input type="checkbox"/> | | 25 |
| hysterotomy | <input type="checkbox"/> | | 26 |
| hysterectomy | <input type="checkbox"/> | | 27 |
| no 2nd trimester operations are performed at this hospital. | <input type="checkbox"/> | | 28 |

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Q. 5. In the period from January 1975 to December 1975, about how many terminations were performed at this hospital?

29-32

(_____)

Q. 6. Is there a quota on how many terminations may be performed each week at this hospital?

Yes

☐

33, 34

If yes, what is the quota per week?

(_____)

No

☐

Q. 7. Are patients requesting terminations at this hospital seen at:

a special clinic for this purpose

general gynaecological clinics

an infertility clinic

general outpatients clinics

at medical officers' private rooms

other (specify)

(_____)

☐
☐
☐
☐
☐
☐
☐

Tick
all
which
apply
35
36
37
38
39
40

Q. 8. Are decisions about each operation at this hospital made by:

the doctor who interviews the patient

the doctor in conjunction with a social worker

the doctor in conjunction with a psychiatrist

two doctors in conjunction with a psychiatrist

two doctors in conjunction with a social worker

a review board

other (please specify)

(_____)

(_____)

☐
☐
☐
☐
☐
☐
☐

Tick
one
only
41

If *all* patients requesting termination of pregnancy at your hospital are referred to *visiting medical officers* please tick box

☐

42

and go to Q.21.

If some patients requesting termination of pregnancy are seen at public clinics *at this hospital* please answer the questions in Section C.

SECTION C. PUBLIC CLINIC PROCEDURES

Q. 9. From the time a patient *first* presents at the hospital requesting termination of pregnancy to the time a *decision* is made about the operation, *which members of your staff does the patient usually see?* (e.g. outpatients sister, registrar, specialist, social worker etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List
in
order
seen
43
44
45
46
47
48

Q. 10. *How long does the initial intake procedure usually take?* (i.e. from time of first presentation to time decision is made)

less than 1 hour

1 - 3 hours

3 - 6 hours

6 - 8 hours

1 - 2 days

2 - 4 days

4 - 7 days

7 + days

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |

Tick
one
only

49

Q. 11. *How long does the patient usually wait from the time the decision is made to the time of the operation?*

less than 1 hour

1 - 3 hours

3 - 6 hours

6 - 8 hours

1 - 2 days

2 - 4 days

4 - 7 days

7 + days

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |

Tick
one
only

50

Q. 12. *Are repeat visits by the patient before the operation ever necessary?*

Yes

No

| |
|--|
| |
| |

51

(If no, go to Q. 14)

Q. 13. *If yes to Q. 12, what are the usual reasons for these visits?*

| |
|--|
| |
| |
| |

52

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Q. 14. Are doctors *rostered* to interview termination of pregnancy patients?

Yes

☐

*If yes.....*are these doctors:

visiting medical officers

on the staff of the hospital

both

other (specify)

(_____)

No

☐

If no, please state the official title of the person who usually does the interviewing

(_____)

| |
|--|
| |
| |
| |
| |
| |

Tick
one
only

53

Q. 15. Are doctors' views on abortion canvassed prior to their being assigned to a roster to *interview* termination of pregnancy patients?

yes

no

does not apply

| |
|--|
| |
| |
| |

54

FIRST TRIMESTER TERMINATIONS

Q. 16. Are doctors *rostered* to do the first trimester termination of pregnancy operations?

Yes

☐

If yes are these doctors:

visiting medical officers

on the staff of the hospital

both

No

☐

If no, please state the official title of the person who usually does the operations

(_____)

| |
|--|
| |
| |
| |

Tick
one
only

55

Q. 17. Are doctors' views on abortion canvassed prior to their being assigned to a roster to *do* first trimester operations?

yes

no

does not apply

| |
|--|
| |
| |
| |

56

SECOND TRIMESTER TERMINATIONS

(Go to Q. 20 if 2nd trimester terminations not performed)

For hospitals performing 2nd trimester terminations

Q. 18. Are doctors rostered to do 2nd trimester termination of pregnancy operations?

57

Yes

☐

If yes are these doctors:

visiting medical officers

on the staff of the hospital

both

☐
☐
☐

Tick
one
only

No

☐

If no, please state the official title of the person(s) who does the operations

(_____)

Q. 19. Are doctors' views on abortion canvassed prior to their being assigned to a roster to do 2nd trimester operations?

58

yes

no

does not apply

☐
☐
☐

(Go to Q. 21)

For hospitals not performing 2nd trimester terminations

Q. 20. If 2nd trimester terminations are not performed at your hospital, are patients referred elsewhere for this service?

59

Yes

☐

If yes, to which hospital are they referred?

(_____)

No

☐

NURSING STAFF

Q. 21. Are nurses *rostered* for termination of pregnancy operations?

60

yes

no

☐
☐

(If no go to Q. 23)

Q. 22. If yes to Q. 21, are *nurses' views* on abortion canvassed prior to their being assigned to a roster?

61

yes

no

☐
☐

REFERRAL

Q. 23. If a termination is *refused*, is the patient *referred elsewhere* for termination?

62

yes

at doctor's discretion

no

☐
☐
☐

(If no, go to Q. 25)

| | | | For office use only |
|--------|---|--------------------------|------------------------------|
| Q. 24. | If the patient is <i>referred elsewhere</i> for termination please indicate <i>the type of agency</i> . | | |
| | private hospital | <input type="checkbox"/> | Tick 63 |
| | public hospital | <input type="checkbox"/> | <i>all</i> 64 |
| | private clinic | <input type="checkbox"/> | which 65 |
| | private doctor | <input type="checkbox"/> | apply 66 |
| | other (please specify) | <input type="checkbox"/> | 67 |
| | (_____) | | |
| | (Go to Q. 27) | | |
| Q. 25. | If the patient is <i>not referred elsewhere</i> for termination, is she <i>referred to other services</i> ? | | |
| | yes | <input type="checkbox"/> | 68 |
| | at doctor's discretion | <input type="checkbox"/> | |
| | no | <input type="checkbox"/> | |
| | (If no go to Q. 27) | | |
| Q. 26. | If the patient is <i>referred</i> to other services please indicate <i>which</i> : | | |
| | pregnancy support agency | <input type="checkbox"/> | Tick 69 |
| | social worker | <input type="checkbox"/> | <i>all</i> 70 |
| | Dept. Social Security | <input type="checkbox"/> | which 71 |
| | maternity home | <input type="checkbox"/> | apply 72 |
| | voluntary organisation e.g. Single Parents Assoc. | <input type="checkbox"/> | 73 |
| | other (specify) | <input type="checkbox"/> | 74 |
| | (_____) | | |
| Q. 27. | If the patient is <i>more than 21 weeks</i> pregnant on presentation, is she <i>referred</i> to other services? | | |
| | yes | <input type="checkbox"/> | 75 |
| | at doctor's discretion | <input type="checkbox"/> | |
| | no | <input type="checkbox"/> | |
| | (If no go to Q. 29) | | |
| Q. 28. | If the patient is <i>referred</i> to other services, please indicate <i>which</i> : | | |
| | pregnancy support agency | <input type="checkbox"/> | Tick 76 |
| | social worker | <input type="checkbox"/> | <i>all</i> 77 |
| | Dept Social Security | <input type="checkbox"/> | which 78 |
| | maternity home | <input type="checkbox"/> | apply 79 |
| | voluntary organisation, e.g. Single Parents Association | <input type="checkbox"/> | 80 Dup |
| | other (specify) | <input type="checkbox"/> | 1-4, 5 (2) |
| | (_____) | | 6 |
| | (_____) | | |

SECTION D. STATISTICAL DATA

VACUUM ASPIRATION PROCEDURES:

Skip to Q.33 if no vacuum aspiration procedures are performed at your hospital.

- Q.29. In the last 3 months, *how many* patients for vacuum aspiration procedures stayed in the hospital:
- | | | |
|---------------------------|--------------------------|------------|
| day of the operation only | <input type="checkbox"/> | 7, 8, 9 |
| one night only | <input type="checkbox"/> | 10, 11, 12 |
| two nights only | <input type="checkbox"/> | 13, 14 |
| three nights only | <input type="checkbox"/> | 15, 16 |
| four nights only | <input type="checkbox"/> | 17, 18 |
| five nights only | <input type="checkbox"/> | 19, 20 |
| six nights only | <input type="checkbox"/> | 21 |
| 7 - 14 days | <input type="checkbox"/> | 22 |
| 14 - 21 days | <input type="checkbox"/> | 23 |
| longer—please specify | <input type="checkbox"/> | 24 |
| (_____) | | |
- Q.30. *How long* does the hospital usually like patients to stay? 25
(_____)
- Q.31. In the last 3 months, *how many* patients returned as inpatients because of complications? 26, 27
(_____)
- Q.32. What was the *total number* of vacuum aspiration patients in the last 3 months? 28, 29, 30
(_____)

2nd TRIMESTER PROCEDURES:

Skip to Q.37 if no second trimester procedures are performed at your hospital.

- Q.33. In the last 3 months, *how many* patients for 2nd trimester procedures stayed in the hospital:
- | | | |
|---------------------------|--------------------------|------------|
| day of the operation only | <input type="checkbox"/> | 31, 32, 33 |
| one night only | <input type="checkbox"/> | 34, 35, 36 |
| two nights only | <input type="checkbox"/> | 37, 38 |
| three nights only | <input type="checkbox"/> | 39, 40 |
| four nights only | <input type="checkbox"/> | 41, 42 |
| five nights only | <input type="checkbox"/> | 43, 44 |
| six nights only | <input type="checkbox"/> | 45 |
| 7 - 14 days | <input type="checkbox"/> | 46 |
| 14 - 21 days | <input type="checkbox"/> | 47 |
| longer—please specify | <input type="checkbox"/> | 48 |
| (_____) | | |
- Q.34. *How long* does the hospital usually like patients to stay? 49
(_____)
- Q.35. In the last 3 months *how many* patients returned as inpatients because of complications? 50, 51
(_____)

Q.36. What was the *total number* of 2nd trimester procedure patients in last 3 months? 52-54
(_____)

SECTION E. CONTRACEPTIVE ADVICE

Q.37. Is the decision to offer contraceptive advice:
the policy of the hospital ☐ Tick one 55
left up to the individual doctor ☐ only

Q.38. Are patients offered contraceptive advice: 56
usually ☐
on request ☐
not at this hospital ☐

Q.39. Please indicate from whom the patient *mainly* receives contracep-
tive advice at each stage of the procedure (*tick one alternative only*
for a, b and c).

| | By social worker | By staff doctor | By doctor performing operation | By nursing sister | Other (specify) | No one | |
|-----------------------------------|------------------------|-----------------------|--------------------------------------|-------------------------|--------------------|-----------|----|
| (a) Prior to operation | | | | | | | 57 |
| (b) After operation in ward | | | | | | | 58 |
| (c) At check- up visit | | | | | | | 59 |

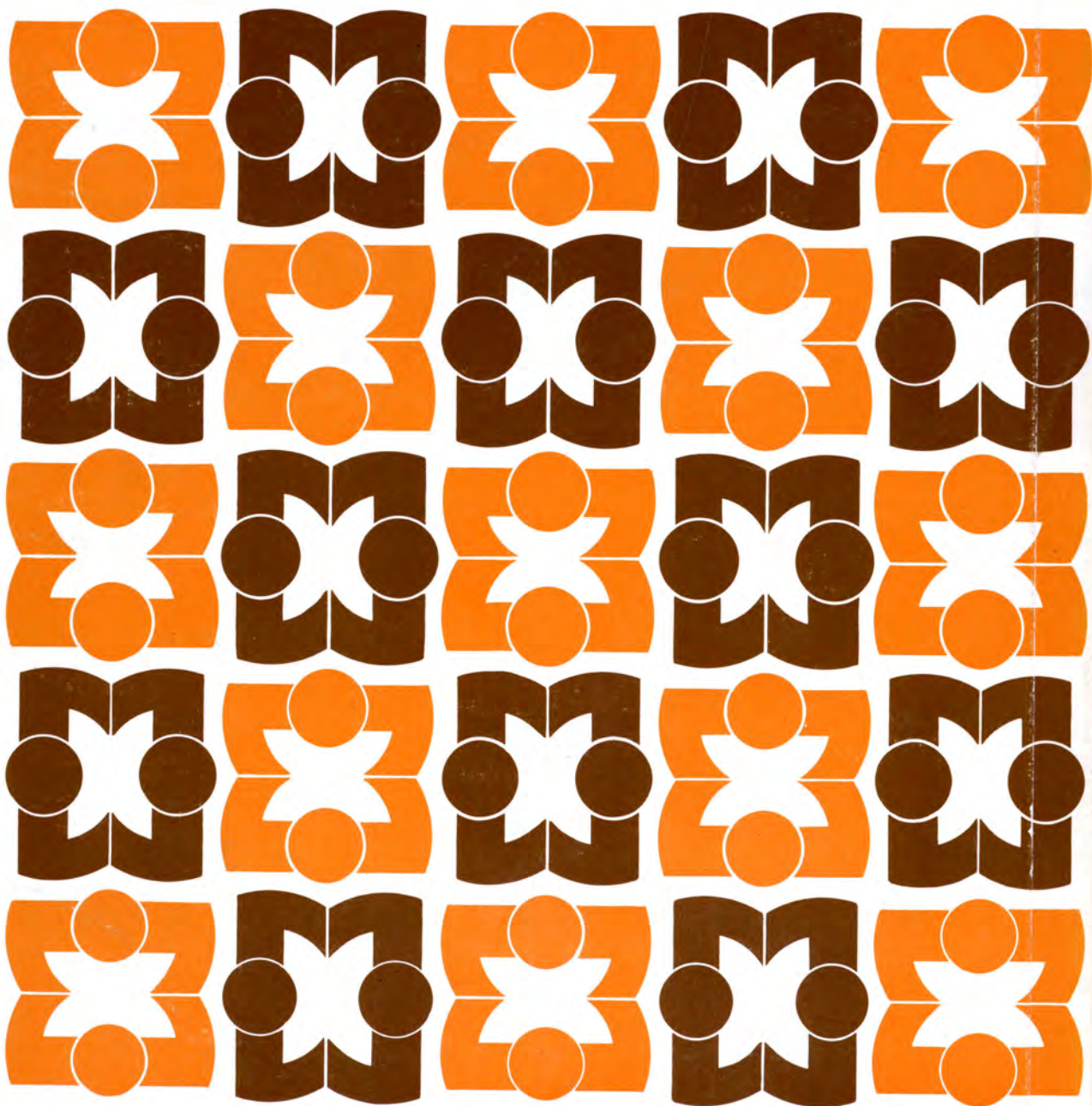
Q.40. Which methods of contraception may be offered to the patient?
all methods, including sterilisation ☐
all methods, excluding sterilisation ☐ Tick one
all methods, excluding rhythm, ☐ only
ovulation and sterilisation ☐
all methods, excluding rhythm and ☐ 60
ovulation but including sterilisation ☐
ovulation and rhythm methods only ☐
ovulation and rhythm methods and ☐
sterilisation only ☐
Other (specify) ☐
(_____)
Does not apply ☐

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SECTION F. CONTRACEPTIVE ADVICE TO MATERNITY PATIENTS IN PUBLIC WARDS

- | | | | | |
|-------|--|--|----------------------------|----|
| Q.41. | Is the decision to offer contraceptive advice to <i>maternity patients</i> : the policy of the hospital left up to the individual doctor | <input type="checkbox"/> <input type="checkbox"/> | Tick <i>one</i> only | 61 |
| Q.42. | Are <i>maternity patients</i> offered contraceptive advice: usually on request not at this hospital | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 62 |
| Q.43. | From whom does the patient <i>usually</i> receive contraceptive advice? visiting medical officer staff doctor nursing sister other (specify) _____ does not apply | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Tick <i>one</i> only | 63 |
| Q.44. | Which <i>methods of contraception</i> may be offered to the patient? all methods including sterilisation all methods excluding sterilisation all methods excluding rhythm, ovulation and sterilisation all methods excluding rhythm and ovulation but including sterilisation ovulation and rhythm methods only ovulation and rhythm methods and sterilisation only does not apply | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 64 |

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